THE SARS COMMISSION

SECOND INTERIM REPORT

SARS AND PUBLIC HEALTH LEGISLATION

The Honourable Mr. Justice Archie Campbell

Commissioner

April 5, 2005

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Dedication

This report is dedicated to those who died from SARS, those who suffered from it, those who fought the disease, and all those affected by it.

Letter of Transmittal

**COMMISSION TO INVESTIGATE
THE INTRODUCTION AND
SPREAD OF SARS IN ONTARIO**

The Honourable Archie Campbell
Commissioner

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April 5, 2005

The Honourable George Smitherman MPP
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Dear Mr. Minister:

Pursuant to the terms of reference, letter of appointment, and Order in Council establishing the independent SARS Commission I submit the attached second interim report.

Yours truly,

Archie Campbell
Commissioner

INTRODUCTION AND EXECUTIVE SUMMARY

INTRODUCTION – FIXING THE SYSTEM

The Commission's first interim report in April 2004[1] recommended major changes in the public health system. The government accepted those recommendations and committed itself to implement them in an ambitious three-year programme. Improvements so far have been significant. But much more work remains to fix the broken public health system revealed by SARS in 2003.

More financial and professional resources are needed, otherwise all the legislative changes and programme reforms will prove to be nothing but empty promises. The test of the government's commitment will come when the time arrives for the heavy expenditures required to bring our public health protection up to a reasonable standard.

This second interim report deals with legislation to strengthen the *Health Protection and Promotion Act*[2] and to enact emergency powers for public health disasters like SARS or flu pandemics. It is produced now to respond to current government plans for further amendments to the *Health Protection and Promotion Act* and radical changes to the *Emergency Management Act.*[3]

The recommendations in this second report are interim, not final or exhaustive. The report touches only on those issues subjected already to sufficient discussion between the government and the health community to make them ripe for action. More extensive consultation is required on issues such as the role of public health in infection control and surveillance in health care facilities, the proposals for emergency powers such as compulsory immunization, the enhancement of infection control standards through amendments to legislation such as the *Public Hospitals Act*[4] and the *Long-Term Care Act, 1994,*[5] and communication between public health and health care facilities.

Suggestions have been received for legislation to strengthen occupational health and safety protection for health workers. That issue will be dealt with in the final report. Occupational health and safety is a vital aspect of the Commission's work. It cannot however be addressed adequately in the limited confines of this report and must be addressed together with the stories of the many health care workers who sacrified so much to battle SARS.

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[1] The Honourable Mr. Justice Archie Campbell, The SARS Commission Interim Report, *SARS and Public Health in Ontario*, April 15, 2004. (Subsequently referred to as the Commission's first interim report.)

[2] R.S.O. 1990, c. H-7.

[3] R.S.O. 1990, c. E-9.

[4] R.S.O. 1990, c. P-40.

[5] S.O. 1994, c. 26.

The Commission continues to investigate the story of SARS. As noted in Appendix C, Commission's Process and Ongoing Work, more than 400 interviews have been held, including victims of SARS and those who lost family members. Their stories and those of health care workers and others who fought bravely to contain SARS have informed these preliminary reports and will be told in the final report. The final report also will give a general account of what happened during SARS and what further steps are necessary, beyond those already recommended in the Commission's two interim reports, to correct the problems disclosed by SARS.

INDEPENDENT MEDICAL LEADERSHIP

Medical leadership that is free of bureaucratic and political pressure is what builds public confidence in the fight against deadly infectious diseases such as SARS.

As Dr. Richard Schabas, a former Chief Medical Officer of Health for Ontario, so aptly described the issue to the Commission at its public hearings:

> I've avoided discussing the impact of politics on this outbreak but I think that to ensure that there's public credibility, that the public understands that the public health officials are acting only in the interests of public health and are not influenced by political considerations, that this has – or that we have to put greater political distance between our senior public health officials and the politicians.

The Commission, noting the government's steps to give the Chief Medical Officer of Health more independence, recommends completion of the work of ensuring that office is independent of political considerations. Leadership and management of Ontario public health should be consolidated in the hands of the Chief Medical Officer of Health. This requires placing public health emergency planning, preparedness, mitigation, recovery, coordination and public risk communication under the direct authority of the Chief Medical Officer of Health. It also requires transfer of operational authority for public health labs, assessors, inspectors and enforcement from the Minister of Health to the Chief Medical Officer of Health.

The Commission also recommends that a parallel measure of independence be given to local medical officers of health, who are the backbone of our protection against disease in Ontario's communities. The Commission noted that in some municipalities the local medical officer of health is buried in the municipal bureaucracy. (More on those problems is found in Chapter 3 Local Governance.) Local medical officers of health must be able to to speak out about local public health concerns without fear of resprisal, dismissal or other adverse employment consequences.

Since SARS, there has been a proliferation of emergency committees throughout the provincial government. Strangely the Chief Medical Officer of Health is not in charge of those committees that bear directly on issues such as pandemic influenza which are central to our defence in public health emergencies. SARS showed us that while cooperation and teamwork are important, it is essential that one person be in overall charge of our public health defence against infectious outbreaks. The Chief Medical Officer of Health should be in charge of public health emergency planning and public health emergency management.

PUBLIC HEALTH GOVERNANCE

Any one of the 36 local health units can be the weak link in Ontario's chain of protection against infectious outbreaks. It takes only one dysfunctional health unit to incubate an epidemic that brings the province to its knees.

Public health problems often result from the system of two governments, provincial and municipal, being involved in the operation of local health units. The public health community is divided into those who think this split governance is satisfactory, or at least salvageable, and those who say 100 per cent of funding and control of local health units should be uploaded to the province.

The Commission has heard continuing reports of municipalities diverting public health staff and funds to other departments, boards of health with members whose sole objective was to reduce health budgets, and medical officers of health fighting municipal bureaucracies and budget constraints to attain a proper standard of public health protection.

Not all local health units are dysfunctional. Some are well governed, but certainly the current weak state of affairs is unacceptable and cannot continue.

It is too early to say the system of divided governance is hopeless.

The government needs to make a clear decision on local health governance by the end of the year 2007, which is after the pending public health capacity review and implementation of recommendations. That gives the government time to decide whether the current system can be fixed with a reasonable outlay of resources or whether control of local public health should be uploaded 100 per cent to the province.

Ontario cannot go back and forth like a squirrel on a road, vacillating between the desire for some measure of local control and the need for uniformly high standards of infectious disease protection throughout the entire province. A clear decision point is required before some deadly infectious disease rolls over the province.

Whatever the ultimate solution to these problems, the Commission recommends five immediate measures required to strengthen public health governance and ensure a uniformly high standard of protection across the province: 1) Protect the local medical officer of health from bureaucratic encroachment; 2) Require by law the regular monitoring and auditing of local health units; 3) Change the public health programme guidelines to legally enforceable standards; 4) Increase provincial representation on local boards of health and set qualifications for board membership; and 5) Introduce a package of governance standards for local boards of health.

Local boards of health must be strengthened to ensure that those who sit on them are committed to and interested in public health, that they clearly understand their primary focus is on the protection of the public's health, and that they broadly represent the communities they serve.

TUNING UP THE LEGAL ENGINE OF PUBLIC HEALTH

The work of protecting Ontarians from infectious disease is driven by the legal engine called the *Health Protection and Promotion Act*. The Act is a complex statute that has served the people of Ontario well since its inception. However, in the aftermath of SARS it is time for the Ministry of Health and Long-Term Care to review the Act to ensure there is no lack of clarity about the precise powers and authority of public health officials to intervene early and manage an outbreak effectively. The review should be conducted in consultation with those who work daily with the Act on the front lines of public health defence.

The Act needs a major overhaul to remove ambiguities that are difficult even for those who work with it daily. The Commission offers four examples of what needs to be done: 1) simplify disease categories; 2) clarify the three streams of power to intervene; 3) simplify the process by which the Chief Medical Officer of Health can exercise powers in Parts III and IV; and 4) strengthen and clarify the powers in s. 22.

The Act must be clear and workable for those who use it to obtain their day to day authority to protect the public's health. Otherwise, uncertainty and confusion will be the refuge for a noncompliant person or institution, and public protection will suffer as public health officials and lawyers try to determine what they can do and when.

STRENGTHENING DAY TO DAY PUBLIC HEALTH POWERS

Public health officials require better access to health risk information and greater daily authority, together with more resources and expertise to investigate, intervene, and enforce.

The Commission has identified seven fields of public health activity that require additional daily authority under the *Health Protection and Promotion Act:*

- in relation to infectious diseases in hospitals;
- to acquire information necessary for them to protect the public from a health risk;
- to investigate health risks to the public;
- for the Chief Medical Officer of Health to establish an adjudication system whereby decisions of local medical officers of health regarding classification of disease may be reviewed;

- for the Chief Medical Officer of Health to issue directives to hospitals and other health care institutions;
- to detain, as a last resort, noncompliant individuals infected with a virulent disease who pose a risk to public health;[6]
- to enter, as a last resort, a private dwelling to apprehend a noncompliant person infected with a virulent disease who poses a risk to public health.[7]

The Commission sees a greater role for public health in infection control, whether it be in a hospital, long-term care facility or private clinic. A medical officer of health must have authority under the *Health Protection and Promotion Act* to monitor, investigate and intervene in cases where infectious diseases or inadequate infection control poses a risk to public health.

It recommends entrenching in the Act that each local public health unit have a presence on hospital infection control committees.

REPORTING INFECTIOUS DISEASE

The conditions of reporting infectious diseases in Ontario are unnecessarily complex, sometimes even illogical. A fundamental weakness is that the *Health Protection and Promotion Act* does not enable public health authorities to get from hospitals and other health care institutions the information needed to protect the public against infectious disease. Without fast access to detailed information about cases of infectious disease, public health cannot investigate, or even be aware of impending danger and therefore cannot protect the public.

The legal obligation to report infectious disease is a foundation of every system of public health legislation. It is necessary not only to encourage reporting but to ensure that the confidentiality laws, designed to protect patient privacy, do not unintentionally undermine the ability of public health authorities to fight the spread of infectious disease.

The Commission recommends a series of changes to the Act to strengthen infection disease reporting. These range from developing standard forms and means of reporting, to clarifying chains of reporting, to educating health care workers about reporting requirements.

The Commission recommends a broad power for the Chief Medical Officer of Health to obtain information, including personal health information, and lab specimens, for the purpose of investigating and preventing the spread of infectious disease.

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[6] See the full text of this recommendation which contains safeguards and limits including early court hearings.

[7] *Ibid.*

PRIVACY AND DISCLOSURE

The Commission recommends statutory amendments to make clear that the duty to disclose personal health information about cases of infectious disease to public health officials prevails over privacy legislation. Privacy, an important value, cannot be allowed to stand in the way of necessary reporting that is required by law to protect the public against infectious disease. Privacy legislation was never intended to impede the flow of vital health information mandated by the *Health Protection and Promotion Act*.

The law should be so clear that lawyers do not have to argue with each other in the middle of a public health crisis about obligations to disclose information to public health. To fight infectious disease, public health authorities require timely access to personal health information.

The Commission recommends amendments to the *Health Protection and Promotion Act* to clarify the ability of medical officers of health to share, with appropriate safeguards, personal health information where necessary to protect the public against the spread of infections.

The power to obtain personal health information brings with it strong obligations to safeguard its privacy. The Chief Medical Officer of Health should review and if necessary strengthen the internal protocols and procedures that safeguard the privacy of personal health information received by public health authorities.

PROTECTING WHISTLEBLOWERS

Health care workers who disclose a public health hazard require legal protection from workplace reprisal. Without whistleblower protection, fear of workplace consequences might discourage the timely disclosure of a public health risk.

Whistleblowing protection should apply to a broad category of people, from nurses to doctors, to porters and clerks and cleaning staff. It should apply to anyone who employs or engages the services of a health care worker, whether part-time, casual, contract or full-time staff. Each and every health care worker in the province should be assured an equal level of protection, regardless of location of employment or employment status.

The Commission recommends that whistleblowing to the local medical officer of health or the Chief Medical Officer of Health be protected by law.

QUARANTINE

Any fight against infectious disease depends above all on public cooperation. SARS could not have been contained in Toronto without the tremendous public cooperation and individual sacrifice of those who were quarantined. In fact, this high level of public cooperation has drawn the attention of foreign researchers.

It is essential to ensure that the spirit of cooperation shown during SARS is not taken for granted. It must be nurtured and promoted.

Therefore, the Commission recommends that all government emergency plans have a basic blueprint for the most predictable types of compensation that can be tailored following the declaration of an emergency.

The *Health Protection and Promotion Act* should be amended to allow unpaid leaves for those quarantined or isolated and those who cannot work because they are caring for a dependent relative stricken in an infectious outbreak.

The Commission also recommends that s. 22(5.0.1) of the *Health Protection and Promotion Act* be amended to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.

The remarkable story of those who suffered quarantine without complaint will be told in the Commission's final report which will also address a number of concerns expressed about the administration of the quarantine powers.

UNTANGLING LEGAL ACCESS

SARS demonstrated weakness and confusion in the legal machinery for the enforcement of health protection orders under the *Health Protection and Promotion Act*, the legal engine that drives health protection. One lawyer told the Commission that their ability during SARS to give clear legal advice was at times hampered by weaknesses in the enforcement portions of the Act:

> During SARS, I would often say when asked if we could do something, 'you can try it, but if we are challenged we may be on shaky legal grounds and the courts will be in a very difficult position.'

Confusion and uncertainty are the only common threads throughout the legal procedures now provided by the *Health Protection and Promotion Act* for public health enforcement and remedies. Confusion and uncertainty can cause delays and delays can cost lives.

The Commission recommends amendment of the *Health Protection and Promotion Act* to address the problems of: a tangle of enforcement powers, procedural gaps in enforcement machinery, overlapping jurisdiction between the Ontario Court of Justice and the Supreme Court of Justice, lack of one-stop shopping for enforcement of orders in respect of infectious diseases, legal uncertainty in initiating and continuing enforcement procedures in court and the lack of systems to ensure legal preparedness in the application of enforcement machinery.

Health professionals and the lawyers who advise them require not only the clear authority to act in the face of public health risks. They require also a simple, rational, effective and fair set of procedures to enforce compliance and to provide legal remedies for those who challenge orders made against them.

RESOURCES FOR PUBLIC HEALTH REFORM

SARS showed that Ontario's public health system is broken and needs to be fixed. Evidence of its inadequacy was presented in the Naylor Report,[8] the Walker Report,[9] and the Commission's first interim report.

Since then, as set out in Appendix B, much progress has been made. But this commendable start is merely the beginning of the effort to fix the public health system. The end will not be reached until Ontario has a public health system with the necessary resources, expertise and capabilities, and this will take years to achieve.

After long periods of neglect, inadequate resources and poor leadership, it will take years of sustained funding and resources to correct the damage. Like a large ship, a public health system, especially one as big and complex as Ontario's, cannot turn on a dime.

The point has to be made again and again that resources are essential to give effect to public health reform. Without additional resources, new leadership and new powers will do no good. To give the Chief Medical Officer of Health a new mandate without new resources is to make her powerless to effect the promised changes. As one thoughtful observer told the Commission:

> The worst-case scenario is to get the obligation to do this and not get the resources to do it. Then the Chief Medical Officer of Health would have a legal duty that she can't exercise.

To arm the public health system with more powers and duties without the necessary resources is to mislead the public and to leave Ontario vulnerable to outbreaks like SARS.

SARS focused on the need for public health to do more to protect us against disease, more by way of planning against threats like pandemic influenza, more by way of increased powers for public health authorities to monitor infectious threats in the community and in health care institutions. It demonstrated that more public health resources are required in many areas, including:

- Laboratory capacity, expertise and personnel;
- Scientific advisory capacity and capabilities;

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[8] National Advisory Committee on SARS and Public Health, *Learning from SARS: Renewal in Public Health in Canada* (Health Canada: October 2003). (Subsequently referred to as the Naylor Report.)

[9] Ontario Expert Panel on SARS and Infectious Disease Control, *For the Public's Health* (Ministry of Health and Long-Term Care: December 2003). (Subsequently referred to as the Walker Interim Report.)

- Epidemiological expertise;
- Surge capacity;
- Infectious disease expertise and personnel;
- Public health human resources excellence and capacity; and
- Infectious disease information systems.

EMERGENCY LEGISLATION

The first goal of public health emergency management is to stop emergencies before they start by preventing the spread of disease. If a small outbreak is prevented or contained, draconian legal powers available to fight a full-blown emergency will not be needed.

Legal powers by themselves are false hopes in times of public crisis. Preparedness and prevention backed by enhanced daily public health powers are the best protection against public health emergencies.

Voluntary compliance is the bedrock of any emergency response. It is essential to compensate those who suffer an unfair burden of personal cost for cooperating in public health measures like quarantine.

The Commission recommends that emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.

Emergency powers are inherently dangerous. They carry the twin dangers of overreaction and underreaction.

The first danger is overreaction. Every emergency power, once conferred, "lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need."[10] To a hammer, everything looks like a nail. To some emergency managers, every problem may look like an opportunity to invoke emergency powers.

The second danger is underreaction. In the face of a deadly new disease with an uncertain incubation period, ambiguous symptoms, no diagnostic tests, uncertainty as to its infectiveness and mechanisms of transmission, and no idea where in the province it may be simmering, decisive action may be necessary that turns out in hindsight to have been excessive.

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[10] Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the race-based internment of Japanese Americans during WW II.

The central task of emergency legislation is to guard against overreaction by providing safeguards and to guard against underreaction by avoiding legal restrictions that prevent the application of the precautionary principle.[11]

There are no pure public health emergencies. Although pandemic influenza might start as a public health emergency, it would rapidly snowball into a general emergency. And big general emergencies that arise outside the field of public health usually have a public health component.

Public health emergencies are unique from typical disasters like floods, fires, power blackouts, or ice storms. In floods and power losses people can take certain protective actions on their own, but they have few personal defences against an invisible virus that can kill them. They must turn to trusted medical leadership.

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to doctors, not to politicians or government managers. It is essential that the public get from the Chief Medical Officer of Health the facts about infectious risks to the public health and the need for precautions and advice on how they can avoid infection. It is essential when public precautions are relaxed, like the removal of protective N95 respirators in hospitals, the re-opening of hospitals, or the declaration that it is business as usual in the health system, that these decisions are made and are seen to be made by and on the advice of the independent Chief Medical Officer of Health free from any bureaucratic or political pressures. It is essential in a public health emergency, or the public health aspects of an emergency such as flood-borne disease, that the Chief Medical Officer of Health be the public face of public communication from the government.

The Commission recommends that emergency legislation provide the Chief Medical Officer of Health with clear primary authority in respect of the medical and public health aspects of every provincial emergency.

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[11] The precautionary principle addresses the problem of underreaction by pointing out that in face of a grave risk it is better to be safe than sorry:

> … the absence of full scientific certainty shall not be used as a reason for postponing decisions where there is a risk of serious or irreversible harm.
>
> Privy Council of Canada, *A Framework for the Application of Precaution in Science-based Decision Making About Risk*, (Ottawa: 2003), p. 2.

Mr. Justice Krever emphasized this principle in the Commission of Inquiry on the Blood System in Canada:

> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.
>
> *Commission of Inquiry on the Blood System in Canada*. Final Report at page 295, see also pages 989 to 994

In times of emergency it is essential to know who is in charge. As Dr. Basrur noted in her appearance before the Justice Policy Committee:

> The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is.

The details of the consultation and cooperation between the Commissioner of Emergency Management and the Chief Medical Officer of Health need not be reduced to legislative form. The inevitable boundaries issues can be solved by cooperation, advance planning and above all by common sense. All that is required is for the Commissioner of Emergency Management and the Chief Medical Officer of Health, whoever may succeed to those jobs from time to time, to park their egos outside the door of the incident room and get on together with the job of managing the emergency. Both require not only confidence in their authority but also a clear acceptance of their mutual roles and limitations.

The Commission reviews competing models of emergency legislation including the "inherent powers" model, an essential element of Ontario's present system which provides no extra legal powers for the management of emergencies and relies instead on unwritten powers. Although this model, under which 218,000 people were evacuated from their homes in the 1979 Mississauga chlorine gas derailment was adequate in pre-Charter times, the advent of the *Charter of Rights and Freedoms*[12] other developments since 1979 suggest it may no longer be adequate today.

Although Ontario got through SARS without any special emergency powers the prospect of pandemic influenza or indeed any outbreak more serious than SARS requires the enactment of explicit public health emergency powers.

Because there is no clear line between public health emergencies and general emergencies it would be wrong to introduce separate, freestanding, parallel emergency regimes, one for public health emergencies and the other for all other big emergencies. The existence of two parallel regimes would bring nothing but legal confusion and administrative disorder, two things no one wants in any emergency.

The government has expressed its intention to proceed with general emergency legislation along the lines suggested in Bill 138, an *Act to Amend the Emergency Management Act* and the *Employment Standards Act, 2000*, which received first reading on November 1, 2004 as a private member's bill produced by the Standing Committee on Justice Policy after public hearings.

The Commission's mandate does not cover general emergency legislation for war, famine, flood, ice storms and power blackouts and the government decision to proceed with Bill 138 is not within the Commission's terms of reference. Because the government has chosen Bill 138 as the vehicle for all emergency legislation including public health emergency legislation the Commission must say something about Bill 138 as a vehicle for public health emergency powers.

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[12] Schedule B, *Constitution Act*, 1982.

The thoughtful work of the Justice Policy Committee in its hearings and its production of Bill 138 must now be completed. A sober second thought is required. That sober second thought must be informed by the regular processes that ordinarily precede the development of any important piece of legislation including in particular a fundamental legal and constitutional review by the Attorney General. The Attorney General has indicated that he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.

The strengths of the Committee process are obvious to anyone who has had an opportunity to review its proceedings. Certain legal concerns, flowing largely from the unusual process imposed on the Committee, are referred to in correspondence between the Commission and the government, set out in Appendix H, and are reviewed in this chapter. The essence of the Commission's concern is the unusual process of proceeding to a draft bill of such profound legal importance without prior policy and operational analysis by departments of government, and without prior legal and constitutional scrutiny by the Attorney General of the kind he has indicated he is now undertaking.

The power of compulsory mass immunization is a paradigm for public health emergency powers. It bristles with legal issues that typify any emergency proposal to interfere with individual liberties for the sake of the greater public good. It exemplifies the legal and policy and practical problems that must be addressed in every analysis of every public health emergency power. Yet it has attracted less policy analysis and discussion than other proposed powers such as the power to ration medical supplies. The power of mass compulsory immunization is not yet ripe for enactment and requires the type of legal, practical, and policy analysis needed for every proposed emergency power.

Ontario's emergency legislation will probably be challenged in court at some time. It will be a major blow to the integrity of the legislation should a court strike down as unconstitutional any part of the statute or any emergency order made under the statute. It is essential to ensure in advance, so much as possible, that the legislation conforms with the Canadian *Charter of Rights and Freedoms*.

The Commission recommends that the government and the Attorney General in their review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to in this chapter.

The Commission reviews a number of legal issues around the powers in Bill 138, for instance the power to compel anyone to disclose any information demanded by the government. The Commission recommends that it be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.

The Commission points to a number of areas that exemplify the need for fundamental review of Bill 138 including the proposed power to override laws such as the *Habeas Corpus Act,*[13] the *Legislative Assembly Act,*[14] the *Human Rights Code,*[15] the *Elections Act,*[16] and the *Courts of Justice Act.*[17]

APPENDICES

The appendices review the action recommended in the Commission's First Interim Report, the work done by the government since then to improve the public health system, and the ongoing work of the Commission.

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[13] R.S.O. 1990, c. H-1.

[14] R.S.O. 1990 c. L-10.

[15] R.S.O. 1990 c. H-19.

[16] R.S.O. 1990, c. E-6.

[17] R.S.O. 1990, c. C-43.

THE SARS COMMISSION

SECOND INTERIM REPORT

SARS AND PUBLIC HEALTH LEGISLATION

1. Medical Independence and Leadership

Public confidence requires that the fight against infectious disease be driven by medical expertise, free from bureaucratic or political pressure. The Commission, in its first interim report, recommended more independence for the Chief Medical Officer of Health. The government has made significant progress in that direction, by amending the *Health Protection and Promotion Act* to give the Chief Medical Officer of Health a greater measure of independence.

The Commission, in this second interim report, recommends[18] that this work be completed by transferring operational authority over public health labs, assessors, inspectors[19] and enforcement provisions of the Act,[20] from the Minister to the Chief Medical Officer of Health. This work must be completed so that the Chief Medical Officer of Health is fully independent of political considerations in respect of medical decisions and direct public health management.

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[18] The Commission's recommendations, if accepted, will have to be put into statutory language by Legislative Counsel, an officer of the Legislative Assembly, with the assistance of departmental lawyers. Although the recommendations sometimes use statutory language they are not offered as statutory amendments but only as a basis for the drafting language chosen by Legislative Counsel to achieve their intent and purpose.

[19] The Commission notes that the *Health Protection and Promotion Act* is confusing in its use of inspectors, under s. 80 and public health inspectors, under s. 41. While the former inspects health units and the latter exercises powers under Part III of the Act, to someone not intimately familiar with the Act, it is somewhat confusing that there are inspectors who are not public health inspectors and public health inspectors who are not inspectors.

[20] Those contained in s. 102(2) of the *Health Protection and Promotion Act* give power to the Minister of Health to apply to a judge of the Superior Court of Justice for an order prohibiting continuation or repetition of the contravention of an order made under the Act.

The Commission also recommends a parallel measure of independence for local medical officers of health, who are the backbone of our protection against disease. Protecting the local medical officer of health from political and bureaucratic influence is as equally important as protecting the Chief Medical Officer of Health. As recommended in the Commission's first interim report, such independence should be coupled with a measure of central medical leadership and direction from the Chief Medical Officer of Health, to ensure protection consistency throughout Ontario's 36[21] semi-autonomous health units.

Similar consolidation is required to ensure that the Chief Medical Officer of Health and local medical officers of health lead public health emergency planning, and are responsible for public health risk communication. A later chapter will deal with the requirement that the Chief Medical Officer of Health assume leadership of the public health aspects of any provincial emergency.

The Commission therefore recommends that the province:

- Complete the work of making the Chief Medical Officer of Health independent of political considerations in respect of medical decisions and direct public health management. This requires the transfer of operational authority from the Minister to the Chief Medical Officer of Health in respect of public health labs, assessors, inspectors and enforcement.

- Amend the *Health Protection and Promotion Act* so that the powers now assigned by law to the local medical officers of health are assigned concurrently to the Chief Medical Officer of Health. These powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.

- Give local medical officers of health independence in medical matters parallel to that of the Chief Medical Officer of Health.

- Provide a greater measure of central provincial medical leadership and control in respect of infectious disease protection and management, over the 36 semi-autonomous health units throughout the province.

- Put provincial public health emergency planning under the authority of the Chief Medical Officer of Health and local public health emergency planning under the authority of local medical officers of health.

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[21] Now 36, with the absorption on April 1 of the Muskoka-Parry Sound Health Unit into neighbouring health units. Ministry of Health and Long-Term Care News Release, "Chief Medical Officer of Health Releases Plan to Strengthen Public Health in Muskoka-Parry Sound," March 9, 2005. This measure, described below, provides a good example of how well the public health system can work under its new leadership and how much there is yet to be done.

- Amend the *Health Protection and Promotion Act* to extend the protection from personal liability contained in s. 95(1) to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health to its expert advisors, to public health employees in the field.

The Commission's Earlier Findings and Recommendations

The management of infectious disease must be driven by medical expertise, not by political expediency. This requires the independence of the Chief Medical Officer of Health in vital areas of medical decision making and direct public health management. Decisions to impose and to relax precautions must be free from political motivation, and must be seen to be free from political motivation.

The Commission so far has not found any evidence of political interference during SARS. But any perception of political interference will sap public confidence and diminish public cooperation. As the Commission noted in its first interim report:

> The Commission on the evidence examined thus far has found no evidence of political interference with public health decisions during the SARS crisis. There is, however, a perception among many who worked in the crisis that politics were at work in some of the public health decisions. This perception is shared by many who worked throughout the system during the crisis. Whatever the ultimate finding may be once the investigation is completed, the perception of political independence is equally important. A public health system must ensure public confidence that public health decisions during an outbreak are free from political motivation. The public must be assured that if there is a public health hazard the Chief Medical Officer of Health will be able to tell the public about it without going through a political filter. Visible safeguards to ensure the independence of the Chief Medical Officer of Health were absent during SARS. Machinery must be put in place to ensure the actual and apparent independence of the Chief Medical Officer of Health in decisions around outbreak management and his or her ability, when necessary, to communicate directly with the public.[22]

The Commission recommended that the Chief Medical Officer of Health be given independence in respect of medical matters, with the right and the duty to report directly to the public on the risk from infectious diseases, and on the measures necessary to protect the community from communicable disease.

The Commission concluded that the office of the Chief Medical Officer of Health needs a greater degree of actual and perceived independence from government. This independence is vital to ensuring public confidence in the Chief Medical Officer of Health's ability to act in their best interest and for the sole purpose of protecting the public health. As Dr. Richard

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[22] The Commission's first interim report, p. 56.

Schabas, a former Chief Medical Officer of Health for Ontario, so aptly described the issue to the Commission at its public hearings:

> I think it [the public health system] has to be arms-length from the political process. I've avoided discussing the impact of politics on this outbreak but I think that to ensure that there's public credibility, that the public understands that the public health officials are acting only in the interests of public health and are not influenced by political considerations, that this has – or that we have to put greater political distance between our senior public health officials and the politicians.

Although the Commission recommended increased independence of the Chief Medical Officer of Health, it also found that there must be an appropriate balance of independence to ensure that there is not so much arms length distance between the Chief Medical Officer of Health and the government so as to impede the accountability of the Chief Medical Officer of Health and her close links with other parts of the provincial health system. As one thoughtful observer noted, it makes more sense for the Chief Medical Officer of Health, if some machinery of independence is added to the office, to be at the table within government rather than a watchdog off in a corner:

> It's not just a question of balancing independence and accountability. It's also a question of ensuring that the Chief Medical Officer of Health can get the job done, can fulfill the delivery of the mandatory public health programmes by the local units and carry out the responsibilities of the Chief Medical Officer of Health under the *Health Protection and Promotion Act*. If the Chief Medical Officer is in the Ministry they are at the table and has a degree of influence from being at the table but also has to be part of a team to some extent. In my opinion a lot can be accomplished by working within the system provided you have a pathway and protection to speak out when needed, both procedural and legal protection.
>
> The Ministry needs to maintain and control policy, funding, and accountability including the transfer payment function to the local boards of health; the Chief Medical Officer of Health should oversee that. The Chief Medical Officer should retain programmatic responsibilities. Being an assistant deputy minister gives you rights of access you don't have if you're a watchdog off in the corner someplace.[23]

The Commission recommended that the Chief Medical Officer of Health:

- Subject to the guarantees of independence set out below, should retain a position as an Assistant Deputy Minister in the Ministry of Health and Long-Term Care.

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[23] *Ibid*, pp. 167-168.

- Should be accountable to the Minister of Health with the independent duty and authority to communicate directly with the public by reports to the Legislative Assembly and the public whenever deemed necessary by the Chief Medical Officer of Health.

- Should have operational independence from government in respect of public health decisions during an infectious disease outbreak, such independence supported by a transparent system requiring that any ministerial recommendations be in writing and publicly available.[24]

The Commission also recommended that the Chief Medical Officer of Health and the Public Health Division assume greater central control over health protection, in particular in relation to infectious diseases. As the Commission noted:

> An uncontrolled outbreak of infectious disease could bring the province to its knees. The province-wide consequences of a failure in infectious disease control are simply too great for the province to delegate infectious disease protection to the municipal level without effective measures of central provincial control. There is little machinery for direct central control over infectious disease programmes. The existing machinery to enforce local compliance with provincial standards is cumbersome and underused. Better machinery is needed to ensure provincial control over infectious disease surveillance and control.
>
> The present distribution of legal powers under the *Health Protection and Promotion Act* gives the local medical officer of health an enormous ambit of uncontrolled personal discretion, which is not ordinarily subject to the review or influence of the Chief Medical Officer of Health. The Chief Medical Officer of Health does have some override powers, and cumbersome machinery does exist under which the province might ultimately bring to heel a rogue board of health. But public health authority in Ontario over infectious disease control, including outbreak management, is primarily that of local officials with no direct accountability to any central authority.
>
> There is no clear accountability to any central provincial authority for local public health decisions to quarantine thousands of people locally. There is no clear accountability to any central authority for local decisions not to quarantine, decisions that could lead to epidemic community outbreak of a deadly disease. This lack of clear central authority could require the Chief Medical Officer of Health, during a virulent outbreak like SARS, to negotiate with separate local medical officers of health whether particular cases should be reported as SARS to the international community, and whether or not the quarantine power should be invoked. This lack of central authority could lead to gross and irrational inequality in the application of the quarantine

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[24] *Ibid*, p. 168.

> powers throughout the province if different local medical officers of health exercised their individual authority without regard to any consistent central guidance.
>
> During a disease outbreak, the international community and organizations like the World Health Organization look for reassurance and credibility to the national and provincial level, not to the particular strength of any local public health board or the particular credibility of any local medical officer of health. Viruses do not respect boundaries between municipal health units. The chain of provincial protection against the spread of infectious disease is only as strong as the weakest link in the 37 local public health units. A failure in one public health unit can spill into other public health units and impact the entire province and ultimately the entire country and the international community. When dealing with a travelling virus, concerns about local autonomy must yield to the need for effective central control.
>
> Although some local medical officers of health treasure their local autonomy from the province and from the Chief Medical Officer of Health, even in relation to outbreak control, there is a degree of recognition that clear and consistent central provincial authority is required for effective protection against infectious disease.[25]

Dr. Richard Schabas, a former Chief Medical Officer of Health, noted at the public hearings:

> I think we need clearer lines of authority within our public health system. At the moment, local public health authorities are not directly answerable or reportable to the provincial authority and I think, particularly in a crisis like SARS, that's something that's important.[26]

The Commission found a striking lack of clarity around the respective accountability of the Chief Medical Officer of Health and the local medical officer of health. As one former medical officer of health said, in response to a question from the Commissioner:

> Q: I am unclear as to what effective powers the Chief Medical Officer of Health has in general terms over the system of protection against infectious disease.
>
> A: Well it is hugely unclear, is it not? … Certainly clarifying the accountability would be a benefit whether the people like the outcome or not because right now it is very vague.[27]

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[25] *Ibid*, pp. 201-202.

[26] SARS Commission Public Hearings, September 30, 2003, p. 28.

[27] The Commission's first interim report, p. 202.

In respect of central control, the Commission made the following recommendation:

> Under the present Act, the legal and practical backbone of local disease control is the local medical officer of health. It makes sense that the initial responsibility should be local. But that initial arrangement makes no sense unless it can be influenced by provincial leadership and can shift, instantly, to the provincial level when a threatened or actual outbreak imperils the provincial public interest.
>
> There are two basic ways to ensure the appropriate measure of central accountability and authority for infectious disease protection.
>
> The first way is to leave essential public health legal powers in the initial hands of the local medical officer of health, subject to some machinery to displace those powers to the Chief Medical Officer of Health during a designated provincial public health outbreak. Although this system maximizes the ordinary local autonomy of local medical officers of health, municipal autonomy is hardly a value of superordinate importance when dealing with viruses that cross municipal, provincial, federal, national, and international boundaries. And the complicated legal machinery necessary to trigger the imposition of central powers, unless made infinitely more simple than the almost medieval system for provincial override of local public health boards, would deprive the provincial override of any practical value in a public health threat.
>
> The second way is to place essential public health legal powers with the Chief Medical Officer of Health, those powers to be exercised on a day to day basis by the local medical officer of health, subject to the ultimate direction of the Chief Medical Officer of Health. This retains all the public health powers under the Act within the presumptive local authority of the local medical officer of health. But it leaves a clear role for provincial leadership and it provides a safeguard and an immediate change of the default position, whenever required, to central provincial authority. This kind of arrangement works well in the justice system where the local Crown Attorney is the agent of the Attorney General, and where the regional senior judge exercises in their region the powers of the Chief Justice, subject to the direction of the Chief Justice.
>
> If the *Health Protection and Promotion Act* were amended to provide that:
>
> - The powers now assigned by law to the medical officer of health are reassigned to the Chief Medical Officer of Health, and
>
> - The powers reassigned to the Chief Medical Officer of Health shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health,

> it would leave the local medical officers of health a clear field to exercise the same powers they have always exercised, subject to ultimate central direction.
>
> Under the old system, such a re-arrangement of powers might raise serious concerns of loss of autonomy on the part of the local medical officer of health including the spectre of political influence from Queen's Park on local public health decisions. While concerns about local autonomy will never go away in any centralized system, the new independence of the Chief Medical Officer of Health and the medical officer of health should go a long way to allay such concerns.[28]

Some public health officials have interpreted this recommendation as requiring the removal of all boards of health and the demotion of local medical officers of health to the status of mere agents of the Chief Medical Officer of Health in each local unit. This, as explained below, was never the intention nor the recommendation of the Commission. The recommendation, exercised with common sense and mutual respect, would leave day to day decisions in the hands of the local medical officer of health with no diminution in practical terms of his or her local autonomy.

The only adjustment the Commission would make in this recommendation is to provide that the local medical officers of health retain all their current powers, to be assigned concurrently to the Chief Medical Officer of Health and to be exercised by the local medical officer of health subject to the central direction and accountability of the office of Chief Medical Officer of Health.

The revised recommendation is this:

- The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health, and
- These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.

More will be said about this later in this chapter.

Chief Medical Officer of Health: What the Government Did

On October 14, 2004, Health Minister Smitherman introduced Bill 124, "*An Act to Amend the Health Protection and Promotion Act*" to give the Chief Medical Officer of Health greater independence, saying:

> I'm delighted to rise in this House today to introduce a bill entitled the Health Protection and Promotion Amendment Act. It amends the *Health*

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[28] The Commission's first interim report, pp. 204-205.

> *Protection and Promotion Act.* The title being a little unwieldy, I prefer to think of it as the independent Chief Medical Officer of Health act …
>
> When there is a health crisis and politicians speak, some people listen. But when there is a health crisis and the Chief Medical Officer of Health speaks, everybody listens. It is at those times, times when diseases like SARS or West Nile are a real threat, that the Chief Medical Officer of Health must be there for his or her patients, all 12 million of them. It is at times like those that the Chief Medical Officer of Health must be able to interact with his or her patients without worrying about what the Minister of Health might think, what the effect might be on the government or what the opposition might say. We learned that lesson as a province during Walkerton, West Nile and SARS. We learned that what Ontarians wanted, what they needed, from their chief doctor was his or her undivided attention.
>
> In the wake of the SARS crisis, both the Campbell and Walker reports recommended that the Chief Medical Officer of Health be independent, with the authority, and in fact with the duty, to communicate with the public whenever he or she sees fit. He wrote that any doubts about the source, timing or motives of public health information have a corrosive effect on confidence, and addressing this perception and reinforcing the centrality of an independent voice for public health is a key step in promoting public health renewal in Ontario.
>
> With the legislation I have introduced today we are taking that step …[29]

Mr. Smitherman, following the tabling of the proposed amendments to the *Health Protection and Promotion Act*, said:

> In the event of a health crisis, Ontarians want to know that their Chief Medical Officer is free of political concerns and interference. An independent CMOH will be able to put the health and safety of Ontarians first.[30]

The amendments received Royal Assent on December 16, 2004, and achieved the following:

- Establishes appointment of the Chief Medical Officer of Health by the Lieutenant Governor in Council, on the address of the Legislative Assembly. Appointment is for a five-year term, which may be renewed.[31]

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[29] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)* (October 14, 2004), pp. 3387-3388.

[30] The London Free Press, "Chief Medical Officer of Health Getting More Independence," October 15, 2004.

[31] Subsections 81(1)-81(3) deals with the appointment, term of office and renewal of the Chief Medical Officer of Health. It sets out that the Lieutenant Governor in Council shall appoint the Chief Medical Officer of Health on the address of the legislative assembly; that the term of appointment is for five years and may be

- Requires that the Chief Medical Officer of Health make an annual report in writing on the state of public health in Ontario, and deliver the report to the Speaker of the Legislative Assembly.[32]

- Gives the Chief Medical Officer of Health the power to communicate with the public, stating that the Chief Medical Officer of Health may make any other reports respecting public health as he or she considers appropriate and may present such a report to the public or any other person he or she considers appropriate.[33]

- Transfers the powers in s. 86 of the *Health Protection and Promotion Act*, previously assigned to the Minister, to the Chief Medical Officer of Health. These powers give the Chief Medical Officer of Health the power to investigate and take action where there is health risk.[34] It allows the Chief Medical Officer of Health to exercise the powers of boards of health and local medical officers of health or to direct a person whose services are engaged by a board of health.[35]

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reappointed for a further term or terms by the Lieutenant Governor in Council on the address of the Legislative Assembly; that he/she may be removed for cause by the Lieutenant Governor in Council on the address of the Legislative Assembly.

[32] Subsections 81(4)-81(6) deal with the annual reports of the Chief Medical Officer of Health. Subsection 81(4) requires the Chief Medical Officer of Health every year to make a report in writing on the state of public health in Ontario, and deliver the report to the Speaker of the Legislative Assembly. The Speaker shall lay the report before the Assembly at the earliest reasonable opportunity. Subsection 81(6) provides that the Chief Medical Officer of Health shall deliver a copy of the report to the Minister at least 30 days before delivering it to the Speaker.

[33] Subsection 81(7) gives the Chief Medical Officer of Health the power to communicate with the public. It states that the Chief Medical Officer of Health may make any other reports respecting the public health as he or she considers appropriate and may present such a report to the public or any other person he or she considers appropriate.

[34] Subsection 86(1) provides:

> Chief Medical Officer of Health may act where risk to health
>
> 86(1) If the Minister is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.

[35] The amendments to ss. 86(2) and 86(3) extend the powers of local boards of health and local medical officers of health in Ontario to the Chief Medical Officer of Health. Those sections provide:

> Same
>
> (2) For the purpose of subsection (1), the Chief Medical Officer of Health,
>
> > (a) may exercise anywhere in Ontario any of the powers of a board of health and any of the powers of a medical officer of health, and

- Transfers to the Chief Medical Officer of Health the power in s. 86.1 to apply to a judge of the Superior Court of Justice for an Order requiring a local board of health to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk caused by the situation.[36]

- Transfers to the Chief Medical Officer of Health the power in s. 86.2 to request a board of health to provide such information, in relation to the

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(b) may direct a person whose services are engaged by a board of health to do, anywhere in Ontario (whether within or outside the health unit served by the board of health), any act,

(i) that the person has power to do under this Act, or

(ii) that the medical officer of health for the health unit served by the board of health has authority to direct the person to do within the health unit.

Authority and duty of persons directed to act

(3) If the Chief Medical Officer of Health gives a direction under subsection (2) to a person whose services are engaged by a board of health,

(a) the person has authority to act, anywhere in Ontario (whether within or outside the health unit served by the board of health), to the same extent as if the direction had been given by the medical officer of health of the board of health and the Act had been done in the health unit; and

(b) the person shall carry out the direction as soon as practicable.

Section 22 Powers

(4) For the purpose of the exercise by the Chief Medical Officer of Health under subsection (2) of the powers of a medical officer of health, a reference in section 22 to a communicable disease shall be deemed to be a reference to an infectious disease.

[36] Section 86.1 provides:

(1) If the Minister is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may apply to a judge of the Superior Court of Justice for an order under subsection (2).

Order of judge of Superior Court of Justice

(2) If an application is made under subsection (1), the judge,

(a) may order the board of health of a health unit in which the situation causing the risk exists to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk caused by the situation; and

(b) may order the board of health of a health unit in which the health of any persons is at risk as a result of a situation existing outside the health unit to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk to the health of the persons in the health unit.

> board of health and the health unit served by the board of health, as the Minister specifies.[37]

Along with these amendments, Dr. Sheela Basrur, Chief Medical Officer of Health, also retained the position of Assistant Deputy Minister, within the Ministry of Health and Long-Term Care, in addition to her role as Chief Medical Officer of Health.[38]

On October 5, 2004, at the Standing Committee on Estimates, Dr. Basrur made the following comments in response to a question as to the nature of her proposed independence, despite the fact that she remained in government as an Assistant Deputy Minister:

> … What I can tell you is that under Operation Health Protection, which is our blueprint for the future for public health, there is a commitment to codifying and strengthening the independence of the Chief Medical Officer of Health through amendments to the *Health Protection and Promotion Act*, the legislation the minister was just referring to.
>
> If I go back to the plan that was announced publicly in June 2004, 60 days after we had received the interim report from Justice Campbell and when we received the final report from Dr. David Walker, who chaired the expert panel on infectious diseases, it was clear that one of the components that needed to be strengthened was the independence of the statutory role that I hold. There were a number of elements that were laid out in that plan relating to the ability and the duty to make reports on matters affecting the health of Ontarians and, secondly, to having a removal of even the perception of political advice or, even worse, interference in public health decision-making. Those elements were set out in that plan of June 2004.
>
> Mr. Baird: Do you feel you have that independence today?
>
> Dr. Basrur: De facto, yes. It is nice to have it codified for clarity and, as I say, to remove any perception that anything untoward might be the case.[39]

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[37] Section 86.2 gives the Chief Medical Officer of Health the power to request a board of health to provide such information, in relation to the board of health and the health unit served by the board of health, as the Chief Medical Officer of Health specifies. Subsection 86.2(2) provides that the Chief Medical Officer of Health may specify the time and the form in which the information must be provided. Subsection 86.2(3) states that the board of health shall comply with such a request. These powers were previously held by the Minister of Health and Long-Term Care.

[38] Ministry of Health and Long-Term Care Press Release: "McGuinty government provides greater independence to Chief Medical Officer Of Health," New Legislation Will Give Ontario's Top Doctor More Power To Protect, Toronto, Dec. 16.

[39] Ontario, Legislative Assembly, Standing Committee on Estimates, *Official Reports of Debates (Hansard)*, (October 5, 2004), p. E-117.

Dr. Basrur's comments were the harbinger of the legislation to come.

Independence of the Chief Medical Officer of Health: Finishing the Task

There seems to be unanimous agreement that the legislative amendments contained in Bill 124 are a step in the right direction. However, there remain a number of powers in the *Health Protection and Promotion Act*, which continue to be exercised by the Minister that should also be transferred to the Chief Medical Officer of Health to ensure the Chief Medical Officer of Health's complete independence.

The *Health Protection and Promotion Act* provides six bundles of powers that are now assigned by law to the Minister. These include the power to investigate by way of inquiry, the power to establish and direct laboratories, the power to appoint inspectors, enforcement powers under s. 102(2), the power to possess a premises as a temporary isolation facility, and the power to appoint assessors and make directions arising from assessor's report. Should these powers remain with the Minister or be transferred in whole or part to the Chief Medical Officer of Health?

Some of these powers are operational in nature and have to do with public health management as opposed to political oversight. These operational powers are an essential part of the managerial stewardship of the public health system, which should reside in a public servant rather than a Minister to the Crown. There are four categories of operational or managerial powers that remain within the domain of the Minister of Health and Long-Term Care, which the Commission recommends be transferred to the Chief Medical Officer of Health:

- Power over assessors;
- Public health laboratories;
- Enforcement powers under s. 102(2); and
- Power to appoint inspectors.

Power Over Assessors

Although the Chief Medical Officer of Health will now hold the power under s. 86(2) to exercise the powers of a board of health where there is a health risk to any person, she lacks the complementary power to order an assessment of a local board of health. This power would enable her to determine whether the board of health is fulfilling its obligations under the Act and, where it is not, to order specific steps be taken to remedy the failure.

The power to order an assessment of a board of health is contained in s. 82 of the *Health Protection and Promotion Act*. It simply provides "The Minister shall appoint assessors for the purposes of this Act." Subsection 82(3) provides the purposes for which an assessor may carry out an assessment. It provides:

> (3) An assessor may carry out an assessment of a board of health for the purpose of,
>
> > (a) ascertaining whether the board of health is providing or ensuring the provision of health programmes and services in accordance with sections 5, 6 and 7, of the regulations and the guidelines;
> >
> > (b) ascertaining whether the board of health is complying in all other respects with this Act and the regulations; or
> >
> > (c) assessing the quality of the management or administration of the affairs of the board of health.

Once an assessment has been completed, s. 83 allows the Minister to give a written direction to the board of health to remedy the problem identified in the assessment.[40] Section 84 allows the Minister to take steps to ensure the direction is carried out.[41]

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[40] Section 83 provides:

> Direction to board of health
>
> 83(1) The Minister may give a board of health a written direction described in subsection (2) if he or she is of the opinion, based on an assessment under section 82, that the board of health has,
>
> > (a) failed to provide or ensure the provision of a health programme or service in accordance with section 5, 6 or 7, the regulations or the guidelines;
> >
> > (b) failed to comply in any other respect with this Act or the regulations; or
> >
> > (b) failed to ensure the adequacy of the quality of the administration or management of its affairs.
>
> Same
>
> (2) In a direction under this section, the Minister may require a board of health,
>
> > (a) to do anything that the Minister considers necessary or advisable to correct the failure identified in the direction; or
> >
> > (b) to cease to do anything that the Minister believes may have caused or contributed to the failure identified in the direction.
>
> Compliance with Direction
>
> (3) A board of health that is given a direction under this section shall comply with the direction,
>
> > (a) within the period of time specified in the direction; or
> >
> > if no period of time is specified in the direction, within 30 days from the day the direction is given.

[41] Section 84(1) sets out the actions that the Minister may take. It provides:

> Power to take steps to ensure direction is carried out

When Dr. Basrur recently appointed an assessor, Mr. Graham Scott, to examine the state of affairs in the Muskoka-Parry Sound Health Unit, she did so pursuant to authority delegated to her by the Minister of Health and Long-Term Care. This salutary example of leadership is discussed below.

It makes little sense to continue to vest in the Minister this corrective power. The Chief Medical Officer of Health must be able to investigate boards of health where there is a concern that duties under the *Health Protection and Promotion Act* are not being met, and to order that they take action to remedy such a failure.

The shift of these assessment and correction powers from the Minister to the Chief Medical Officer of Health is necessary to ensure that such decisions are made, and seen to be made, exclusively on public health considerations. To leave the power with the Minister is to invite the perception and fuel speculation that the decision to bring a local board to account or to leave it alone is influenced by political considerations. This danger is particularly great with the active political role of so many members of local boards of health.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the powers in ss. 82 through 85 to the Chief Medical Officer of Health.**

84(1) If, in the opinion of the Minister, a board of health has failed to comply with a direction under section 83 within the period of time required under subsection 83 (3), the Minister may do whatever is necessary to ensure that the direction is carried out, including but not limited to,

(a) providing or ensuring the provision of any health programme or service in accordance with sections 5, 6 and 7, the regulations and the guidelines;

(b) exercising any of the powers of the board of health or the medical officer of health of the board of health;

(c) appointing a person to act as the medical officer of health of the board of health in the place of the medical officer of health appointed by the board;

(d) providing advice and guidance to the board of health, the medical officer of health of the board of health, and any person whose services are engaged by the board of health;

(e) approving, revoking or amending any decision of the board of health, the medical officer of health of the board of health, or any person whose services are engaged by the board of health; and

(f) accessing any record or document that is in the custody or under the control of the board of health, the medical officer of health of the board of health, or any person whose services are engaged by the board of health.

Public Health Laboratories

Another important area of responsibility under the Act, provincial public health labs, remains under the direction of the Minister. Subsection 79(1) provides that the Minister may "establish and maintain public health laboratory centres at such places and with such buildings, appliances and equipment as the Minister considers proper." Subsection 79(2) provides that the Minister "may give direction from time to time to a public health laboratory centre as to its operation and the nature and extent of its work, and the public health laboratory centre shall comply with the direction." Currently, the labs fall under the domain of the Laboratories Branch of the Health Services Division of the Ministry of Health and Long-Term Care. The Central Public Health Lab has a non-medical director who reports to an Assistant Deputy Minister, also a non-medical person. If the Chief Medical Officer of Health is to hold both the responsibility to ensure the protection of the public health of Ontario and the power to act independently to ensure that she fulfills that responsibility, the public health labs must be part of the transfer of power.

The provincial lab has a critical role to play in public health. Part of the Ministry of Health, the Ontario Public Health Laboratory is a network consisting of one provincial laboratory in Toronto, known as the Central Public Health Laboratory, and 11 regional labs. Approximately half of the 500 technical and support staff are employed in the Toronto facility.[42] Their role is described as follows:

> The public health labs provide diagnostic microbiology testing in support of public health programmes, outbreak management and control, and microbiology reference services for the province in areas where front line microbiology diagnostic testing is not available.[43]

One observer described their importance to the smooth functioning of the Ontario public health system as follows:

> But with a public health laboratory, while they do deal with individual patients, it doesn't have that patient as their number one priority despite the fact that, you know, the patient is very important. Their number one priority is understanding how this one patient with that particular disease, whatever it may be, may impact on the greater public. And so a public health laboratory has as its main focus not the one patient but how that one patient may impact on the greater public.

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[42] Dr. Margaret Fearon, Medical Microbiologist, Central Public Health Laboratory, Ontario Ministry of Health and Long-Term Care, *SARS: The Ontario Public Health Lab's Experience*, presented at the National Forum on Laboratory Reform, (Toronto: March 23-4, 2004), p. 3. (Subsequently referred to as the Fearon Presentation.)

[43] The Fearon Presentation, p. 3.

The Walker report,[44] the Naylor Report and the Commission's first interim report noted serious inadequacies in Ontario's public health laboratory capacity during SARS. As noted in the Commission's first interim report, SARS highlighted both the need for a well-resourced, smooth functioning lab, and the abysmal state of the Ontario's Central Public Health Laboratory. The provincial laboratory in Toronto quickly became swamped with specimens but it was ill-equipped and unprepared to deal with the expanded demands of an outbreak like SARS. Consequently, as Dr. Naylor noted in his report, many of the private hospitals either by-passed the provincial lab altogether, sending specimens directly to the National Microbiology Laboratory in Winnipeg, or they handled the testing themselves, becoming as Dr. Naylor described "the *de facto* and unfunded referral centres for Toronto SARS testing."[45]

Laboratories are at the heart of our protection against infectious disease. The Chief Medical Officer of Health, with her independence and professional qualifications, should have the responsibility to establish and maintain the provincial public health labs. This includes ensuring that they are properly resourced. Furthermore, there is a need to ensure that the Central Public Health Lab is connected to and works effectively with the Public Health Division of the Ministry of Health and Long-Term Care. Many of those interviewed by the Commission remarked that the Central Public Health Lab tended to operate as a separate silo, rather than an integrated part of the Public Health Division. One expert noted that during SARS the Public Health Branch had trouble getting information from the public health laboratory, even though they were part of the same Ministry. This disconnect caused great concern for many experts who came forward to help with the Ontario response. As one of them noted:

> The lab was a huge issue … What we were really worried about, too, was the number of cases that were positive on the lab test that were negative clinically. Were they missing cases and were these going to be the ones that were transmitting the cases even further, because they were our real worry, because that's how we would lose containment, by the asymptomatic cases … We had trouble getting access to any of the lab information at the Ministry, even though it was the same Ministry.

It is only logical that the Chief Medical Officer of Health should have within her basket of powers the ability to direct the provincial public health labs as a vital aspect of public health protection. This direction should not come from an elected official without medical training or public health expertise.

SARS showed us also that it is essential that one person be in overall charge of our public health defence against infectious outbreaks. While cooperation and teamwork are required in any large endeavor, an effective defence requires that all public health aspects be under the leadership of one person. Why hive off from the Chief Medical Officer of Health the responsibility for public health laboratories? Why put that function under a separate division of the Ministry under different leadership? Essential links in our public health defence against infectious disease, like the public health laboratories, should be under the leadership of the Chief Medical Officer of Health, not an independent bureaucratic entity. SARS showed that this kind of bureaucratic barrier leads only to problems.

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[44] Ontario Expert Panel on SARS and Infectious Disease Control, *For the Public's Health*, (Ministry of Health and Long-Term Care: December 2003) (subsequently referred to as the Walker Interim Report).

[45] Naylor Report, p. 33.

The Walker panel recommended that, in the short term, the Ministry of Health and Long-Term Care would retain control of the public health labs:

> "Short-term: continued management of public health laboratory system, increasing role of Public Health Division."[46]

In the long-term, however, Walker recommended transferring the public health labs to the proposed Ontario Health Protection and Promotion Agency:

> "Long-term: transfer of responsibility for management of the public health laboratories through coordination with Agency."[47]

In respect of the Ontario Health Protection and Promotion Agency, Walker recommended the following role for the Chief Medical Officer of Health, to ensure clear linkages between the Chief Medical Officer of Health and the Agency:

> It is proposed that strategic direction for the Agency be set by the Chief Medical Officer of Health (CMOH) and day to day operational and scientific leadership be provided by a Chief Executive Officer. The final Walker report also recommended: " … that the Chief Medical Officer of Health be an ex-officio member of the board to ensure a link to the broader direction and functioning of the Agency."[48]

On June 22, 2004, Minister Smitherman released the three-year public health action plan called "Operation Health Protection."[49] Its purpose is to institute the recommendations in the Commission's first interim report, and the Walker Report. This plan indicated that the Ontario Centre for Disease Control (called the Ontario Health Protection and Promotion Agency) and its new laboratory would begin operations in the 2006/7 fiscal year. It also called for the Ministry of Health to "undertake a formal review of the public health laboratory system in [fiscal] 2004/5 to determine the functional and procedural enhancements required for the system to provide appropriate tests and perform optimally during outbreaks and non-outbreak situations."[50]

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[46] Ontario Expert Panel on SARS and Infectious Disease Control, *For the Public's Health: A Plan of Action*, (Ministry of Health and Long-Term Care: April 2004), p. 127. (Subsequently referred to as the Walker Final Report).

[47] The Walker Final Report, p. 127.

[48] The Walker Final Report, p. 92.

[49] Ministry of Health and Long-Term Care, "Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario" (June 22, 2004). (Subsequently referred to as Operation Health Protection).

The recommendation that the Chief Medical Officer of Health assume responsibility for Ontario's Public Health Laboratories is intended as a short-term transfer of powers pending the development of the Ontario Health Protection and Promotion Agency and the transfer of powers in accordance with the recommendations in the Walker Report, with which this Commission concurs. Once developed the Agency will be responsible for the public health laboratory system. The Agency in turn will come under the direction of the Chief Medical Officer of Health. It only makes sense for the Chief Medical Officer of Health to have authority over public health laboratories at this time, pending the development of the Health Protection and Promotion Agency. Conversely it makes no sense to leave with the Minister the medical power to direct the public health laboratory as to its operation and the nature and extent of its work.

Recommendation

The Commission therefore recommends that:

- **The Minister's power under s. 79 of the *Health Protection and Promotion Act,* to establish and direct public health laboratory centres be transferred from the Minister to the Chief Medical Officer of Health, until such time as the establishment of the Ontario Health Protection and Promotion Agency and the transfer of power over the laboratories in accordance with the recommendations of the Walker Report.**

Enforcement Powers

Three separate provisions of the *Health Protection and Promotion Act* address the issue of enforcement. These three sections, s. 35, s. 86.1 and s. 102, authorize court action in the face of noncompliance.

If the powers of the local medical officer of health are assigned concurrently to the Chief Medical Officer of Health as recommended, the Chief Medical Officer of Health would have enforcement powers under s. 35 in addition to the enforcement powers acquired under s. 86.1 following the recent amendment to the Act.

Subsection 102(1) allows the person who made an order or the Chief Medical Officer of Health, or the Minister, to apply to the Superior Court of Justice for an order restraining a contravention of the Act. That subsection provides:

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[50] Operation Health Protection, Appendix B, p. 5.

> 102(1) Despite any other remedy or any penalty, the contravention by any person of an order made under this Act may be restrained by order of a judge of the Superior Court of Justice upon application without notice by the person who made the order or by the Chief Medical Officer of Health or the Minister.

Subsection 102(2) authorizes an application to the Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order. That subsection provides:

> 102(2) Where any provision of this Act or the regulations is contravened, despite any other remedy or any penalty imposed, the Minister may apply to a judge of the Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention by the person committing the contravention, and the judge may make the order and it may be enforced in the same manner as any other order or judgment of the Superior Court of Justice.

More will be said below about the confusing nature of these two parts of this provision. It makes little sense that the Chief Medical Officer of Health should have the power to request an order restraining in s. 102(1) but lacks the power to request an order prohibiting continuation or repetition in s. 102(2). These are operational powers, not political oversight powers, and they should be in the hands of the Chief Medical Officer of Health rather than the Minister.

Recommendations[51]

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the power in s. 102(2) to the Chief Medical Officer of Health.**
- **The *Health Protection and Promotion Act* be amended to remove from s. 102(1) the Minister as a listed person who may exercise that power.**

Powers over Inspectors

Another important enforcement power that currently remains with the Minister is the responsibility for inspectors under the *Health Protection and Promotion Act*. Section 80(1) sets out the power of the Minister to appoint inspectors.[52] Subsection 80(2) sets out the duty of an inspector and s. 80(3) allows the Minister to set limits on the duty or authority of inspectors:

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[51] These recommendations are directed towards this section if it remains as it is. As discussed in Chapter 10, Legal Access, the sections need to be clarified and amended in their entirety, and set out in a clear, comprehensive enforcement section of the Act.

> (2) An inspector shall make inspections of health units to ascertain the extent of compliance with this Act and the regulations and the carrying out of the purpose of this Act.
>
> (3) The Minister in an appointment may limit the duties or the authority or both of an inspector in such manner as the Minister considers necessary or advisable.

Subsection 80(4) provides that the Minister may require an inspector to act under the direction of, or report to, the Minister, the Deputy Minister of Health, the Chief Medical Officer of Health or other officer in the Ministry.

It seems logical that if the Chief Medical Officer of Health has the responsibility to ensure compliance with the *Health Protection and Promotion Act* across the province, she must also have the complimentary power to appoint and direct the inspectors who conduct inspections to determine the extent of a health unit's compliance with the Act. These are powers of management and enforcement, not powers of political oversight, and therefore should reside with the Chief Medical Officer of Health, not the Minister.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the powers in s. 80 to the Chief Medical Officer of Health.**

Powers to Remain with the Minister of Health and Long-Term Care

Once these four statutory bundles of power (assessors, public health labs, enforcement and inspectors) are transferred to the Chief Medical Officer of Health, two important powers remain with the Minister: the power to investigate by way of inquiry and the power to take possession of premises for the purposes of temporary isolation.

The power to investigate by way of inquiry is contained in s. 78 of the *Health Protection and Promotion Act*. Section 78 provides that the Minister may make investigations respecting the causes of disease and mortality, and may direct anyone to conduct such an investigation, exercising the powers of a commission under Part II of the *Public Inquiries Act*.[53] It is this power, reflected in the Commission's terms of reference and Order in Council, that enables the work of this Commission. There is no good reason to transfer this power to the Chief Medical Officer of Health. It is not a power that requires any medical expertise or knowledge about infectious disease. Medical expertise is not required to determine that the public interest requires an investigation into some matter of public concern involving the health system. This power belongs with the Minister of Health, an elected official, answerable in the Legislative Assembly and to the public. For this reason the Commission recommends no change to the power of the Minister under s. 78 to launch an investigation into the causes of disease and mortality.

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[52] Subsection 80(1) provides:

> The Minister may appoint in writing one or more employees of the Ministry or other persons as inspectors.

[53] Part II of the *Public Inquiries Act*, R.S.O. 1990, c. P. 41, sets out the power of a Commissioner. In particular, s. 7 allows the Commissioner to compel evidence:

Section 87 of the *Health Protection and Promotion Act* allows the Minister to commandeer any building for use as a temporary isolation facility or as part of a temporary isolation facility.[54]

A commission may require any person by summons,

(a) to give evidence on oath or affirmation at an inquiry; or

(b) to produce in evidence at an inquiry such documents and things as the commission may specify, relevant to the subject-matter of the inquiry and not inadmissible in evidence at the inquiry under section 11.

[54] Possession of premises for temporary isolation facility

87(1) The Minister, in the circumstances mentioned in subsection (2), by order may require the occupier of any premises to deliver possession of all or any specified part of the premises to the Minister to be used as a temporary isolation facility or as part of a temporary isolation facility.

Extension

(1.1) An order under subsection (1) shall set out an expiry date for the order that is not more than 12 months after the day of its making and the Minister may extend the order for a further period of not more than 12 months.

Grounds for order

(2) The Minister may make an order in writing under subsection (1) where the Chief Medical Officer of Health certifies to the Minister that,

(a) there exists or there is an immediate risk of an outbreak of a communicable disease anywhere in Ontario; and

(b) the premises are needed for use as a temporary isolation facility or as part of a temporary isolation facility in respect of the communicable disease.

Delivery of possession

(3) An order under subsection (1) may require delivery of possession on the date specified in the order.

Hearing and submissions

(4) The Minister need not hold or afford to any person an opportunity for a hearing or afford to any person an opportunity to make submissions before making an order under subsection (1).

Order for possession

While some have submitted to the Commission that this power be transferred to the Chief Medical Officer of Health, the Commission recommends that it remain within the authority of the Minister of Health and Long-Term Care.

The power in s. 87 is considerable. It empowers the Minister to commandeer any building. It differs in nature from purely operational public health powers and reaches beyond the health care system and those directly affected by disease. It thus requires a different level of nonmedical accountability than that required for purely medical or operational powers. Under the current system the Minister is directly accountable for any exercise of this extraordinary power. On the other hand, the Minister may only make such an order on the advice of the Chief Medical Officer of Health. The latter must certify that there exists or

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(5) Where a judge of the Superior Court of Justice is satisfied on evidence upon oath,

(a) that there has been or is an immediate risk of an outbreak of a communicable disease anywhere in Ontario;

(b) that the premises are needed for use as a temporary isolation facility or as part of a temporary isolation facility in respect of the communicable disease; and

(c) that the occupier of the premises,

(i) has refused to deliver possession of the premises to the Minister in accordance with the Minister's order under subsection (1),

(ii) is not likely to comply with the Minister's order under subsection (1), or

(iii) cannot be readily identified or located and as a result the Minister's order under subsection (1) cannot be carried out promptly,

the judge may issue an order directing the sheriff for the area in which the premises are located, or any other person whom the judge considers suitable, to put and maintain the Minister and any persons designated by the Minister in possession of the premises, by force if necessary.

Execution of order

(6) An order made under this section shall be executed at reasonable times as specified in the order.

Application without notice

(7) A judge may receive and consider an application for an order under this section without notice to and in the absence of the owner or the occupier of the premises.

Compensation

(9) The occupier of the premises is entitled to compensation from the Crown in right of Ontario for the use and occupation of the premises and in the absence of agreement as to the compensation the Ontario Municipal Board, upon application in accordance with the rules governing the practice and procedure of that board, shall determine the compensation in accordance with the *Expropriations Act*.

Procedure

(10) Except in respect of proceedings before the Ontario Municipal Board in accordance with subsection (9), the *Expropriations Act* does not apply to proceedings under this section.

there is an immediate risk of an outbreak of a communicable disease anywhere in Ontario and that the premises are needed for use as a temporary isolation facility or as part of a temporary isolation facility in respect of the communicable disease. The current system thus ensures a double level of accountability, political and medical, for the exercise of this power.

Recommendation

The Commission therefore recommends that:

- **The powers in s. 78 (appointment of inquiry) and in s. 87 (commandeering buildings for use as temporary isolation facilities) remain as they are, to be exercised by the Minister of Health and Long-Term Care.**

Parallel Independence of Local Medical Officers of Health

The local medical officers of health throughout the province are the backbone of our protection against infectious disease. They, like the Chief Medical Officer of Health, require independence from political and bureaucratic pressures in relation to the prevention and management of infectious disease.

The medical officer of health, as noted earlier, requires a degree of independence parallel to that enjoyed by the Chief Medical Officer of Health, which was recently the subject of amendments to the *Health Protection and Promotion Act.*[55] Local medical officers of health must have both the duty and the power to speak out publicly about local public health concerns. These must include the power to bring to the attention of the public a local board's failure or refusal to comply with its obligations under the Act. The local medical officer of health must be able to do so without fear of reprisal, dismissal, or other adverse employment consequences.

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[55] Subsection 81(1.3) was recently added to require the Chief Medical Officer of Health to report annually to the public on the state of public health in Ontario and to authorize them to make any other reports respecting public health as she considers appropriate. The relevant sections are:

Annual Report

(4) The Chief Medical Officer of Health shall, in every year, make a report in writing on the state of public health in Ontario, and shall deliver the report to the Speaker of the Legislative Assembly.

Laying before Assembly

(5) The Speaker shall lay the report before the Assembly at the earliest reasonable opportunity.

Minister's Copy

(6) The Chief Medical Officer of Health shall deliver a copy of the report to the Minister at least 30 days before delivering it to the Speaker.

Other Reports

(7) The Chief Medical Officer of Health may make any other reports respecting the public health as he or she considers appropriate, and may present such a report to the public or any other person he or she considers appropriate.

As will be discussed in greater detail in the following chapter, in many municipalities the local medical officer of health is buried within the municipal governance structure. Their desire to freely communicate on behalf of those citizens living in their unit, in relation to health risks, is tempered by their desire to preserve their jobs. Ironically, one medical officer of health, while supporting greater independence, noted their inability to voice that opinion publicly:

> Interestingly enough, with the announcement related to the independence of the Chief Medical Officer of Health, a reporter asked wouldn't it make sense if that was parallel at the community level as well? And of course in the interests of preserving my job, I actually said I could not comment. So I think that that sort of instinctively appeals and is understood because I think the reasons were very well understood why the Chief Medical Officer of Health needed that independence.

There is a strong concern in the medical officer of health community that their ability to communicate with the public is hampered by their lack of independence and their struggles within the municipal governance structure. One local medical officer of health described how hard it is to get the public health message out to the public:

> … for many years I insisted on preparing my own annual report and we printed it and we distributed it through libraries and all the usual venues. The regional corporation actually at that time never had an annual report of their own and they heard about this, so they decided to do their own annual report, I mean apart from their financial statement, which of course they've always had to do, but they decided they needed a glossy annual report so for awhile I was allowed to have the two middle pages that related specifically to the health of the residents and over the last two, three years that has disappeared as well, I gave up fighting for that.

As another medical officer of health described the problem:

> … communication and public health risk communication is different from corporate communication and that is a very difficult concept for regional corporations to understand, they just feel they own all of the communication because what it means to them is ensuring that pathways are in place for re-election.

Yet another medical officer of health described the struggle to communicate with the public:

> I recall one incident where the regional municipality wanted to speak out on a communicable disease investigation. They [the region] make unhealthy public health policy decisions all the time and because I'm embedded in the

> regional municipality, I can't speak out, and I think what you're seeing as well is a disturbing trend of integrating public health risk communications into the municipal communications. The problem with that is the latter often serves as a press secretary function to the regional politicians. And I think you need to give a great deal of consideration to this one, more generally, with respect to emergencies. You need to protect the independent voice of the medical officer of health with respect to public health risk communications, particularly in the municipal setting, because there are conflicts all the time. This may be the opportunity to clean it up so that we can speak authoritatively, locally, on public health risk standards. My hope would be that we would get the same sort of protection that the Chief Medical Officer of Health presumably is going to get, maybe even more as a part of the independence package that we're expecting in the Fall.

The problem is particularly acute when it may be necessary to speak out against a health risk created by the municipality itself:

> If you subsume the public risk communications machinery in the corporate communications machinery, then your strong public health messages may be sanitized or killed because your message may look bad. [What about] a region who is charged with violations under the Ontario Water Resources Act, failure to report abnormal test results. As you know, we're required to issue boiled water advisories and as such we are also in the loop with respect to reporting, as is the Ministry of the Environment. Clearly there would be a conflict of interest in us speaking out, if in fact there was a problem with reporting to public health, if in fact it undermined the defence of the Region with respect to charges under the Ministry of the Environment. I mean this is just one of many, many examples, but I think public health risk communication is very, very important.

It is unacceptable that medical officers of health are restricted in their ability to tell the public what it has a right to know about health risk. Public health leadership and risk communication must be the clear domain of the local medical officer of health. The *Health Protection and Promotion Act* must authorize them to speak out on behalf of public health, without fear of adverse employment consequences. They have the duty, and require the power, to tell the public directly about any health risk. Local politics and bureaucratic turf wars have no place in the protection of the public's health. It is vital to ensure the ability of the medical officer of health to speak out. It is equally vital, as noted in the following chapter, to protect the local medical officer of health from the municipal bureaucracy and ensure his or her direct authority for the administration of staff and public health resources. Both changes are necessary to ensure the ability of the local medical officer of health to protect the public.

The independence recently given to the Chief Medical Officer of Health by statutory amendment should now be extended to those responsible locally for our day to day health protection. As one local medical officer of health said:

> I think those of us who are in public health as physicians, really believe in the ability to improve people's health, and that's why we got in the job in the first place, and that's why I'm here, because I want to help shape the system.

They must have the legal authority and independence.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to provide for every local medical officer of health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:**
    - **Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health:**
        - **To report every year publicly on the state of public health in the unit. This report must be provided to the local board of health and the Chief Medical Officer of Health 30 days prior to it being made public; and**
        - **To make any other reports respecting the public's health as he or she considers appropriate, and to present such a report to the public or any other person, at any time he or she considers appropriate.**
    - **Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any medical officer of health in respect of the good faith exercise of those reporting powers and duties.**

A Continued Need for Greater Central Control over Health Protection

The present system of central accountability and control is impractical and cannot continue. When a board of health fails in its obligations, the cumbersome enforcement provisions of ss. 82 through 86 are the only recourse for the Chief Medical Officer of Health. As the Commission observed in the first interim report:

> The difficulty is that the assessment and compliance machinery is infinitely complicated, replete with notices, directions, orders, procedures before the Health Services Appeal and Review Board and the Superior Court of Justice and appeals therefrom. It more resembles an international peacekeeping operation than it resembles effective machinery to enforce basic health protection standards across the province.

These powers had to be invoked in the Muskoka-Parry Sound Health Unit debacle, described below. The process in that case was time consuming and resource intensive. The Chief Medical Officer of Health, as Ontario's health protection leader, requires a simpler process of intervention than the complex process set out in the *Health Protection and Promotion Act*. The assurance of a uniform level of health protection across the province, particularly in relation to infectious diseases, demands that the Chief Medical Officer of Health have the power to intervene quickly and effectively whenever necessary to protect the public. Health protection across the province relies not only on effective boards of health, but also on knowledgeable, effective local medical officers of health. It is the local medical officers of health who have the authority to make orders under the *Health Protection and Promotion Act*, in the interests of protecting the public's health. Curiously, although the Chief Medical Officer of Health is the leader for health protection in the province, she does not have the same powers as the local medical officers of health. Moreover, she has no ability to direct persons whose services are engaged by a board of health, short of taking over the board of health.

The Chief Medical Officer of Health can only exercise direct powers under s. 86 of the Act, which requires that she determine that "a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons." In such a case, the Chief Medical Officer of Health may investigate the situation and take any action, as she considers appropriate, to prevent, eliminate or decrease the risk. Subsection (2) states that where these criteria are met, she can exercise the powers of the local medical officer of health or the board of health, or direct the services of a person whose services are engaged by the board of health. Although this standard of intervention is not high, it is nonetheless a legal hurdle to intervention. As a legal hurdle it attracts all the legal issues associated with the intervention of a superior authority into the affairs of an autonomous local entity.

That is the wrong way to view the collegial relationship between the Chief Medical Officer of Health and the 36 local medical officers of health scattered throughout the province. The relationship, although collegial, cannot be entirely equal in an era in which the rapid communication of deadly disease requires a strong measure of central accountability and control. The ability of the Chief Medical Officer of Health to intervene where necessary in a local health unit should be part of a seamless continuum where daily authority is exercised by the local medical officer of health subject to the direction, whenever necessary, of the authority of the Chief Medical Officer of Health. The exercise of central leadership and authority cannot be impeded by this formal legal hurdle more appropriate to an era when local autonomy necessarily trumped central control. The public interest in unified accountability and control requires that there be no formal legal impediment to the local involvement and leadership of the Chief Medical Officer of Health whenever it is required in the wider provincial interest.

Ontario is fortunate in its many skilled, experienced and dedicated local medical officers of health who do a remarkable job delivering services and protecting the public. But this does not detract from the need for the Chief Medical Officer of Health to be able to intervene where the local authorities need leadership, assistance, or intervention.

Threats to public health may arise suddenly and without warning, overwhelming the capacity of a local health unit and local medical officer of health. It is essential in such cases that central resources and leadership be deployed immediately not only to assist the local unit but also to guard against the spread of disease to the rest of the province.

If a West Nile problem or a future SARS or some other hazard cannot be easily contained because the situation overwhelms the resources of the local health unit, they should be able to count on the Chief Medical Officer of Health to do what is necessary, whether that be deploying resources from other health units or the province.

For this reason alone, the Chief Medical Officer of Health requires the ability to step in immediately without the hurdle of s. 86, described above.

The problem with the present lines of authority between the Chief Medical Officer of Health and the local health units is that they harken from a pre-SARS era when it seemed fine for municipalities to run the show as independent legal entities. SARS showed that public health is a provincial concern, not just a local concern. Infectious diseases do not respect the geographic boundaries of Ontario's local health units. As noted so often, an infectious disease outbreak in one health unit could bring the whole province to its knees within days. Local autonomy has many advantages, but not when it comes to infectious disease problems that threaten the larger Ontario public interest.

The recommendation, for concurrent Chief Medical Officer of Health and medical officer of health powers, exercised locally by the medical officer of health subject to the ultimate central direction of the Chief Medical Officer of Health, does not mean that the local medical officers of health lose their duties and obligations under the Act or their local leadership and authority. They are still in charge at the local level, better protected against local bureaucratic and political interference, and subject only to the central leadership and direction of the politically independent Chief Medical Officer of Health.

Nor does the recommendation mean that local medical officers of health would lose their ability to address their community needs. It does not mean a cookie cutter approach to public health across the province. The public health challenges faced in a major urban center such as Toronto are not identical to those faced in a small northern community such as Dryden, and neither of those are identical to those faced by a border community such as Niagara Falls. In critical aspects such as infection control, surveillance, and management, as well as emergency preparedness, one would expect that the Chief Medical Officer of Health would lead strongly in setting clear standards that must be met in each health unit. This is vital to ensuring a seamless level of protection against infectious disease across the province. In other activities, however, like those unique to a particular community, the expectation is that the local medical officer of health would have wide discretion in programme planning and delivery of services. Requiring that mandatory standards be met and giving the Chief Medical Officer of Health a strong central role, do not mean that all health units' programmes must be carbon copies of each other. Nor does it mean that the local medical officer of health would lose the ability to tailor the programmes to the particular region. The recommendation is not to remove their current powers or independence, but simply to give the Chief Medical Officer of Health concurrent power to reinforce central leadership and control when needed.

One local medical officer of health expressed this concern:

> I think the principle that you want to set up a framework whereby the Chief Medical Officer of Health can exercise authority at the local level when needed is a good principle. I think that you are right that that exercise is more likely to happen on issues of communicable disease control than it is in other areas. I am just wondering what the best way to do that is. I guess the local MOH is almost always going to be closer to the situation and in a better position by virtue of having information and having worked with it probably for a little while before the issue comes up of whether the Chief Medical Officer of Health should step in.
>
> I would almost rather see the presumption being that there is local autonomy with a mechanism for override rather than delegation with the option of taking the authority back and there may be some legal differences in those two ways of structuring it. I think the default should be that the person on the scene in the first instance has the responsibility for making decisions.

This thoughtful concern is met by the practical reality that no Chief Medical Officer of Health fulfilling his or her overall provincial responsibilities will have the time, the inclination or the resources to tinker inappropriately with local decisions. Under the present system, whatever its future, local autonomy is required on a day to day basis because you simply cannot run the whole province from Toronto. Day to day management of health protection will devolve necessarily on the local medical officer of health subject to central leadership and direction by the Chief Medical Officer of Health, without legal hurdles, when it seems reasonable.

Under this recommendation it would be business as usual. The local medical officer of health under the present practice runs public health locally but consults with the Chief Medical Officer of Health when particularly sensitive issues arise on which the local medical officer of health wants advice and support from the Chief Medical Officer of Health. This recommendation retains the initial presumption of local control. There is no proposed increase in actual power for the Chief Medical Officer of Health who already has the power of intervention in s. 86, described above. This recommendation simply removes the legalistic baggage potentially attracted by s. 86 and makes the central leadership of the Chief Medical Officer of Health more direct.

Others have raised the concern that transferring the powers to the Chief Medical Officer of Health creates the potential for abuse of these powers by the Chief Medical Officer of Health. While they do not raise this concern about the current Chief Medical Officer of Health, they worry about the use of this power in the hands of an unknown successor.

As noted above and discussed in greater detail below, the independence of the Chief Medical Officer of Health, as well as the greater independence of the local medical officer of health, combined with the ability and security to speak out publicly, would act as a deterrent against any inappropriate use of the powers of the Chief Medical Officer of Health.

One local medical officer of health expressed the concern that problems will arise not necessarily when the Chief Medical Officer of Health decides she needs to intervene, but when members of the public or others in the community seek to use her authority to undermine or challenge the independence and authority of the local medical officer of health:

> I guess a good situation would be one in which the Chief Medical Officer of Health found it relatively easy to step in where needed at their discretion, but the people whom the local medical officer of health is dealing on a day to day basis would not find it easy to appeal as it were over the head of the local MOH. You do not want to give the people that we have to work with on a regular basis the idea that if they do not like the MOH's decision, they can just bump it up a level.
>
> … is it possible if you do not want to have criteria that would set boundaries, is it possible to indicate a level of concern so that it makes it clear that it is not a day to day avenue that is open to people, some language around extraordinary circumstances or posing a risk to the health of the population. I do not know what would work but a little bit of guidance to people trying to interpret the legislation.

The Chief Medical Officer of Health must ensure that it is clear to everyone, through policy and practice, that her authority and intervention is not available to those who seek to use it simply to second guess an unpopular decision of the local medical officer of health. As recommended above, the strengthened independence of the local medical officer of health recommended below by the Commission will provide an effective safeguard against any inappropriate use of the powers of the Chief Medical Officer of Health.

The Commission proposes a system of dispersed central authority whereby the local medical officer of health exercises in ordinary times local authority concurrent with that of the Chief Medical Officer of Health. Local autonomy of the local medical officer of health is the ordinary position. Local autonomy is secured by the newly recommended independence of the local medical officer of health from bureaucratic interference or political pressure. Local autonomy is fortified by the newly recommended duty and power of the local medical officer of health to speak out publicly in respect of health risks. The local autonomy of the medical officer of health is subject only to the central leadership and ultimate direction by the Chief Medical Officer of Health that is required to ensure a uniformly strong level of protection across the 36 separate local health units, particularly in relation to infectious disease.

Recommendations

The Commission therefore recommends that:

- **The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health.**

- **These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.**

Public Health Emergency Preparedness and Response

SARS showed us also that it is essential that one person be in overall charge of our public health defence against infectious outbreaks. While cooperation and teamwork are required in any large endeavor, effective defence against infectious disease requires that all public health aspects of that defence be under the leadership of one person.

Since SARS, emergency committees have proliferated and multiplied within the government and particularly within the Ministry of Health and Long-Term Care. Within the Ministry of Health and Long-Term Care, the Health Emergency Management Committee plans for emergencies, the Ontario Health Pandemic Influenza Plan Steering Committee plans for pandemic influenza emergencies, the Emergency Management Unit manages emergencies, and the Executive Emergency Management Committee makes executive decisions. There are also additional layers of committees at the centre of government.

Strangely, the Chief Medical Officer of Health is in charge of none of these committees which are central to Ontario's defence against public health emergencies.

A case in point is the Emergency Management Unit, established in December 2003, to oversee all the Ministry's emergency management activities. Under the leadership of a dedicated long-time official in the Ministry of Health and Long-Term Care, the Unit plays a central role in many crucial public health emergency planning activities:

- It is the lead for pandemic influenza planning, including overseeing the steering committee it established to oversee the development of the health pandemic flu plan.

- It is developing a smallpox emergency response plan.

- It is developing a radiation health response plan.

- It is working on the health component of the Foreign Animal Disease Plan.

The Unit's extensive activities have necessitated the development of draft Terms of Reference for a Scientific Advisory Team to:

> Provide advice to EMU based on evidence and best practices on medical/scientific aspects of health emergency planning and response, including but not limited to:
>
> - Personal protection for health care workers;

- Medical response to and treatment of chemical, radiological and nuclear agents;
- Patient triage treatment and transport priorities;
- Needs analysis for pharmaceutical and other antidotes;
- Interaction and integration among health care providers; and
- Educational and research initiatives.

> Review and provide input into relevant policies, standards and guidelines as directed by EMU.
>
> Upon request, act as a Scientific Response Team to be convened to support the Ministry's health emergency response (specific membership to reflect the needs of the emergency).
>
> Provide scientific advice specific to health emergency threats upon request of the Director.[56]

For expertise on infectious disease, the Unit is also developing a relationship with the Provincial Infectious Diseases Advisory Committee (PIDAC) that may require a memorandum of understanding. A recent summary of the EMU's activities related to PIDAC said:

- Expertise on new and emerging infectious diseases is provided by PIDAC.
- [EMU] Scientific Advisor and Director, EMU members of PIDAC.
- Work under way to develop a memorandum of understanding regarding mutual expectations in an emergency.
- Requests for specific advice on infectious diseases provided on an ad hoc basis, e.g., consolidation of SARS directives, confirmation of basic personal protective equipment in response to an infectious disease.[57]

The Unit's web site is also the primary vehicle for public risk communication on significant public health issues. The portion of the web site aimed at the general public contains information on avian flu, influenza pandemic and health advisories. The portion of the web site intended for health care professionals contains technical information on pandemic influenza, avian flu, including screening tools, infection control standards, and important health notices.

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[56] Ministry of Health and Long-Term Care, Emergency Management Unit, "Update on EMU Reference Groups," February 21, 2005.

[57] *Ibid.*

The March 1, 2005, organizational chart of the Ministry of Health and Long-Term Care shows the Emergency Management Unit as a separate entity, with an apparent reporting relationship to the Associate Deputy Minister. There is no reporting link from the Emergency Management Unit to the Chief Medical Officer of Health.[58]

This is clearly a unit that should be under the direct authority of the Chief Medical Officer of Health. Nothing could be more central to the mandate of that office in protecting Ontarians from deadly infection. It makes no sense to hive off from the Chief Medical Officer of Health the responsibility for public health planning for smallpox and pandemic influenza. It makes no sense to put the responsibility for smallpox and pandemic influenza planning under a separate division of the Ministry. Public health emergency planning requires the leadership of the Chief Medical Officer of Health, not an independent bureaucratic entity. SARS showed that this kind of bureaucratic barrier leads only to problems.

A recent "Important Health Notice" from the Ministry of Health in respect of avian flu was distributed on the Unit's web site and was co-signed by the Associate Chief Medical Officer of Health and the head of the Emergency Management Unit, an official with no medical qualifications and no reporting relationship to the Chief Medical Officer of Health. To those familiar with the confusion during SARS arising from the split responsibility between the Commissioner of Emergency Management and the Chief Medical Officer of Health, this arrangement produces a shock of recognition.

Dr. Basrur explained to the Justice Policy Committee the problem during SARS of this very kind of arrangement:

> … there were a multitude of directives issued under the authority of the two commissioners – the Commissioner of Emergency Management and the Commissioner of Public Health – and many comments back that people were unsure who was in charge because there were two signatories; there were always two people who had to be consulted.[59]

In the event of a provincial pandemic influenza emergency, can we expect three signatures, the Commissioner of Public Safety and Security, the head of the Ministry of Health and Long-Term Care's Emergency Management Unit, and the Chief Medical Officer of Health, two of whom are not medically trained? To ask the question is to demonstrate that the Ministry's present organization of emergency responsibility needs amendment to put the Chief Medical Officer of Health clearly in charge.

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[58] See Appendix G to this Report.

[59] Ontario, Legislative Assembly, Standing Committee on Justice Policy (subsequently referred to as the Justice Policy Committee), *Official Report of Debates (Hansard)*, Public Hearings, August 18, 2004, p. 142.

Another big problem during SARS that resulted from too many people managing the same problem was the multiplicity of information requests. The Commission repeatedly heard from SARS front line workers that much of their time was spent responding to multiple requests from various parts of the government, particularly within the Ministry of Health and Long-Term Care. As one Ministry employee who worked at the epi-unit told the Commission:

> Compounding that as we went on, the demand for data and data analysis just became enormous. You know, the mailing list got to be this humungous monster. Everybody wanted the data. Everybody wanted certain charts developed.

As the demands for information grew, people started duplicating work. The insatiable requests for information cascaded down to the front line workers and local medical officers of health and their staff, significantly contributing to their frustration and fatigue. It is important to guard against the creation of multiple responding agencies and committees, which can, by their very multiple existence, create barriers to effective emergency response. Should another infectious disease emergency hit the province, we are at risk, under the current emergency system within the Ministry of Health and Long-Term Care, of repeating the very problems that arose during SARS, with multiple separate groups demanding case information and feeling entitled to it by nature of their emergency response mandate.

This is not to say that the Chief Medical Officer of Health or the local medical officers of health would work in isolation or be responsible for each and every detail of public health emergencies. That is an impossible responsibility. Much of the planning for future emergencies involves the creation of partnerships and working groups. While it is essential to have partnerships and working groups in place prior to an outbreak there still needs to be a single leader, identifiable both internally and externally. As one expert from outside Ontario who worked at the provincial level during SARS described the problem;

> Outbreak management 101 would never set up the situation for something like this where you do not have a single person defined as being overall responsible. That does not mean that the person works alone in isolation and would report to someone with legislative powers to do certain things but you do not do something as confusing as this with two leaders …

SARS caught Ontario's public health system unprepared. Unified preparedness and planning is a vital piece of armour in our protection against infectious disease. It must be a priority not only for the Public Health Division but also for every local health unit.

More will be said about this and the important issue of who is in charge, in the chapter on Emergency Legislation. Public health emergency planning is addressed here, in the context of Chief Medical Officer of Health leadership, as an area of the Ministry of Health and Long-Term Care that must be put under the direction and control of the Chief Medical Officer of Health.

Key members of the SARS Scientific Advisory Committee suggest that it is important for the EMU, the Ministry's operational response to a public health emergency and its lead in preparedness planning and implementation and management, to report directly to the Chief Medical Officer of Health. They recommend:

> If the Chief Medical Officer of Health is the incident commander during a health emergency, it follows therefore that all other health sectors are accountable to the Chief Medical Officer of Health. This was the premise during the SARS outbreak and worked to the extent that proper command and control structures were exercised, and now the Emergency Management Unit of the Ministry of Health and Long-Term Care is the coordinating structure by which provincial health care providers and organizations would report to the Chief Medical Officer of Health during an emergency and this should recognized in legislation. During the SARS outbreak there was duplication of information and efforts from within the MOHLTC. One central Emergency Management Unit reporting to the Chief Medical Officer of Health will avoid duplication and confusion.

The Commission endorses their recommendation.

Public health emergency preparedness and planning implementation must be the responsibility of the medical officer of health not only at the provincial level but also at the local level. It is not enough to ensure that the central provincial machinery is prepared. The local machinery in each part of the province must be equally prepared. Local preparation is essential not only to ensure a consistent province-wide response in each locality, but also because some public health emergencies will be local in nature without any immediate province-wide implications.

As one local medical officer of health noted, there must also be clarity around the leadership role of the local medical officer of health in respect of local health emergencies, and when responding to a provincial health emergency, in partnership with the Chief Medical Officer of Health:

> We have not talked at all about health emergencies and who is in charge and what is a health emergency and in fact what is the role of the MOH at the local level with respect to health emergencies if at all and does there need to be a corresponding bulking up of the mandatory health programmes and services and guidelines under that with respect to health emergencies … But I guess why I am asking this question is I meet with and chair a health emergency preparedness kind of committee that involves the hospitals, long-term care and so forth … I pulled this together because nothing is happening locally and I was shocked to learn that despite there being a health emergency management unit created in the Ministry of Health, it has given hospitals, long-term care, and so forth no direction whatsoever to have emergency plans. So, to the extent there are other actors that need to be involved in responding to a local health emergency that does not require a

> provincial response for example, how does that happen, and what powers and duties can be brought to bear to deal with that situation.

In addition to preparedness and planning, the Chief Medical Officer of Health and the local medical officers of health must have the lead role in public health emergency mitigation, management, recovery, coordination and risk communication. Above all, there must be clarity around roles and responsibilities.

As Dr. Bonnie Henry, former associate Medical Officer of Health for Toronto, noted in her testimony before the Justice Policy Committee, there is currently little clarity around roles and responsibilities:

> A few other little things that came out: we have conflicting legislation right now about who has to do what in an emergency. I think that needs to be either umbrella legislation through EMA or we need to look at the Emergency Management Act, the Public Hospitals Act and the HPPA separately to rectify some of the conflicting legislative pieces.[60]

Dr. Henry stressed the importance of local public health leadership in a public health emergency:

> One of the things we need to remember is that all the actual physical, hands-on management of emergencies happens at the local level. So while we absolutely need to have the authority and decision-making and a command-and-control structure at the provincial level-and I absolutely agree with that-the authority then needs to go to the local people to do what they need to do within their own local jurisdictions, because we know the quirks of our own jurisdictions. Some of the problems we've run into, for example, are that under the Public Hospitals Act, hospitals are not necessarily required to be involved with their local emergency response organizations. That needs to be changed. There's nothing that requires them to be involved at the local level; they report to the province. That, I think, is an issue we have been trying to deal with.[61]

There is currently nothing in the *Health Protection and Promotion Act* that requires the local medical officer of health to be responsible for public health emergency preparedness, management and recovery or for public health risk communication. While there are scattered references to outbreak planning, emergency planning and risk communication in the Mandatory Guidelines, they are general in nature and do not make it clear what must be done and by whom.[62] None of these references put the local medical officer of health in charge at the local level during a public health emergency or in charge of public health risk communication.

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[60] Justice Policy Committee, Public Hearings, August 18, 2004, p. 148.

[61] *Ibid*, p. 148.

[62] For example, s 2.0 of the Mandatory Guidelines says that services provided by the board of health are expected to be planned and delivered by staff with the required technical/professional skills including skills in risk communication (one of many skills identified). Section 5.0 requires the board of health to have an outbreak

One local medical officer of health described the need for reform as follows:

> If you had a mandatory programme or standard so that every health unit shall work out a health emergency plan, a public health emergency plan, and that part of your function is, in the event of a public health emergency, public communication or risk assessment. I think that you have to do it in two places. I think that you have to deal with s. 5(1) and s. 7 … because if you do that then it gives you the authority, it helps you get money from the municipalities. I would also go a step further with respect to public health risk communications, I would also strengthen s. 67 so that there are explicit powers for the MOH to speak out with respect to health emergencies. You and I would agree that that may be covered under s. 67(1) but the people that you need to get to are the municipalities. You need to have some tools at hand to force them to pay for programmes and the way you do that is by declaring something mandatory. And when you do that, not only does the board of health and an obligated municipality have to provide and pay for it, but also it legitimizes the province providing the funding. So that is one of the advantages of naming those two areas in s. 5 and perhaps providing standards under s. 7. But I would also beef up in general the communications page under s. 67 and I think that there are enough other tools in the Act to allow us to get the job done, notably s. 13, s. 14 and infectious disease s. 22.

Another medical officer of health added:

> I think the standards would have to be very prescriptive as to the elements of the emergency response plan, and they should be tested on an annual basis. I think there should be support in the Public Health Division to ensure that the quality of the plan across the province is acceptable and that we have people to liaise with.

The *Health Protection and Promotion Act* must be amended to include local public health emergency planning, preparedness, mitigation, management, recovery, coordination and risk communication as a responsibility of the local medical officer of health. A number of submissions to the Commission have recommended:

> Amend section 5 of the *Health Protection and Promotion Act* to include "public health emergency preparedness, management and recovery and public health risk communication."

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response plan, and s. 6.0 requires the board to ensure input to hospital infection control programmes in health units and nursing homes and homes for the aged on their outbreak contingency plan. However, nothing in the mandatory guidelines puts the local medical officer of health squarely in charge of health emergency planning, preparedness, mitigation, management, coordination, recovery or risk communication.

Similarly, the *Health Protection and Promotion Act* must clearly state that at the provincial level, the Chief Medical Officer of Health is in charge of public health emergency planning, preparedness, mitigation, management, recovery, coordination and risk communication.

Subsection 6.2(1) of the *Emergency Management Act* requires that each municipality, minister of the Crown and designated agency, board, commission and other branch of government submit a copy of their plan to the Chief, Emergency Management Ontario, and must ensure that they have the most current plan.[63] The *Health Protection and Promotion Act* should be amended in a parallel manner so as to require that local medical officers of health and local boards of health submit a copy of their emergency plan to the Chief Medical Officer of Health and ensure that she has the most recent copy.

Dr. Bonnie Henry, described to the Justice Policy Committee the need for better integration at the local level and between the various health units:

> I think one of the really key things we need to work on is integration of emergency management programmes at the local level. Right now, everybody is required to have an emergency management program. Health is involved to varying extents in different places but it is not a major player at the local level. As well, we need to integrate with our neighbours. Our emergency management organization has a very different structure than does Peel, for example, but we share a lot of common borders and a lot of common issues, and how we do things is quite different.[64]

As Dr. Henry also said:

> I think the whole issue of hospitals and other parts of the health care organization being part of our critical infrastructure is something that's not well understood by people in the emergency side of the world – the people who look after critical infrastructure even at the city level. Hospitals are a provincial entity. Do they fit into us, or is the province looking after them? Who's going to make sure they get the power back on soon? Who's going to make sure they get the trucks to fill their generators so the patients don't suffer?[65]

The local medical officer of health must ensure that hospitals, long-term care facilities, nursing homes, outreach programmes, shelters, correctional institutions, and other organizations and institutions that would be involved in, or affected by a public health emergency, have their own emergency plans fully integrated with the public health emergency plan, all under the overall policy direction of the Chief Medical Officer of Health.

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[63] Subsection 6.2(1) provides:

> Every municipality, minister of the Crown and designated agency, board, commission and other branch of government shall submit a copy of their emergency plans and of any revisions to their emergency plans to the Chief, Emergency Management Ontario, and shall ensure that the Chief, Emergency Management Ontario has, at any time, the most current version of their emergency plans. 2002, c. 14, s. 10.

[64] Justice Policy Committee, Public Hearings, August 18, 2004, p. 149.

[65] *Ibid.*

With this additional responsibility must come additional resources to ensure that the local medical officer of health and the Chief Medical Officer of Health can actually fulfill these expanded duties. To do otherwise would be to create an unacceptable risk.

Recommendations

The Commission therefore recommends that:

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health under the *Health Protection and Promotion Act.***

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication under the direction of the local medical officer of health be added to the list of mandatory public health programmes and services required by s. 5 of the *Health Protection and Promotion Act.*[66]**

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[66] Section 5 provides:

> Mandatory health programs and services
>
> 5. Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:
>
> > 1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
> >
> > 2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
> >
> > 3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases.
> >
> > 4. Family health, including,
> >
> > > i. counselling services,
> > >
> > > ii. family planning services,
> > >
> > > iii. health services to infants, pregnant women in high risk health categories and the elderly,
> > >
> > > iv. preschool and school health services, including dental services,

- **The Emergency Management Unit of the Ministry of Health and Long-Term Care be moved to the Public Health Division with its Director reporting directly to the Chief Medical Officer of Health.**

- **The *Health Protection and Promotion Act* be amended to require that each local board of health and each medical officer of health provide to the Chief Medical Officer of Health a copy of their general public health emergency plan and any incident specific plans and ensure that the Chief Medical Officer of Health has, at any time, the most current version of those plans.**

Protection from Personal Liability

The *Health Protection and Promotion Act*[67] now protects from personal liability for damages a limited class of people who act in good faith in the intended execution of their duties under the statute. These people include board of health members, medical officers of health and associate medical officers of health, and public health inspectors. Section 95 provides:

> No action or other proceeding for damages or otherwise shall be instituted against a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector for any act done in good faith in the execution or the intended execution of any duty or power under this Act or for any alleged neglect or default in the execution in good faith of any such duty or power.

Although these individuals are personally protected from being sued, anyone damaged by their negligence still has the right to sue the board of health itself.[68] The provision thus protects a limited number of public health workers personally while it preserves the rights of anyone allegedly damaged by their actions.

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v. screening programs to reduce the morbidity and mortality of disease,

vi. tobacco use prevention programs, and

vii. nutrition services.

4.1 Collection and analysis of epidemiological data.

4.2 Such additional health programs and services as are prescribed by the regulations.

5. Home care services that are insured services under the *Health Insurance Act*, including services to the acutely ill and the chronically ill.

[67] Section 95(1).

[68] Section 95(3).

The provision is cast too narrowly. By protecting public health officials like the medical officers of health and withholding protection from others like public health nurses, it withholds protection from those who may need it most. It also excludes the Chief Medical Officer of Health.

Section 95 of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.

This amendment will ensure that public health workers are adequately protected against personal liability for damages while preserving the right of anyone allegedly damaged to sue the worker's employer.

Recommendation

The Commission therefore recommends that:

- **Section 95 of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.**

Conclusion

To avoid the problems that arose during SARS and to increase our protection against infectious disease, it is necessary to increase the independence of the Chief Medical Officer of Health and the local medical officers of health and consolidate public health leadership in the hands of the Chief Medical Officer of Health.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the powers in ss. 82 through 85 (power over assessors) to the Chief Medical Officer of Health.**

- **The Minister's power under s. 79 of the *Health Protection and Promotion Act*, to establish and direct public health laboratory centres be transferred from the Minister to the Chief Medical Officer of Health, until such time as the establishment of the Ontario Health Protection and Promotion Agency and the transfer of power over the laboratories in accordance with the recommendations of the Walker Report.**

- **The *Health Protection and Promotion Act* be amended to transfer the power in s. 102(2) (enforcement powers) to the Chief Medical Officer of Health.**

- **The *Health Protection and Promotion Act* be amended to remove from s. 102(1) the Minister as a listed person who may exercise that power.**

- **The *Health Protection and Promotion Act* be amended to transfer the powers in s. 80 (power over inspectors) to the Chief Medical Officer of Health.**

- **The powers in s. 78 (appointment of inquiry) and in s. 87 (commandeering buildings for use as temporary isolation facilities) remain as they are, to be exercised by the Minister of Health and Long-Term Care.**

- **The *Health Protection and Promotion Act* be amended to provide for every local medical officer of health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:**
  - **Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health:**
    - **To report every year publicly on the state of public health in the unit. This report must be provided to the local board of health and the Chief Medical Officer of Health 30 days prior to it being made public; and**
    - **To make any other reports respecting the public's health as he or she considers appropriate, and to present such a report to the public or any other person, at any time he or she considers appropriate.**
  - **Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any medical officer of health in respect of the good faith exercise of those reporting powers and duties.**

- **The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health.**

- **These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.**

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health under the *Health Protection and Promotion Act.***

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication under the direction of the local medical officer of health be added to the list of mandatory public health programmes and services required by s. 5 of the *Health Protection and Promotion Act.***

- **The Emergency Management Unit of the Ministry of Health and Long-Term Care be moved to the Public Health Division with its Director reporting directly to the Chief Medical Officer of Health.**

- **The *Health Protection and Promotion Act* be amended to require that each local board of health and each medical officer of health provide to the Chief Medical Officer of Health a copy of their general public health emergency plan and any incident specific plans and ensure that the Chief Medical Officer of Health has, at any time, the most current version of those plans.**

- **Section 95 (protection from personal liability) of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.**

2. Local Governance

Introduction

Ontario's 36 local health units are the front line of protection against infectious disease. That chain of protection is only as strong as its weakest link. Some health units are well governed, some poorly. Because viruses respect no boundaries, it is little comfort that some are well governed. It takes only one dysfunctional health unit out of 36 to incubate an epidemic that brings the province to its knees within weeks.

These weak links often result from the system of two governments, provincial and municipal, being involved in the operation of local health units.

Problems caused by split provincial-municipal governance run deep in our public health system. So many members of the public health community have expressed frustration, and have presented evidence of dysfunctionality in the present arrangement, that something must be said about it in this interim report.

Dr. Sheela Basrur, Ontario's Chief Medical Officer of Health, appointed after SARS, has initiated measures to address these problems. Only time will tell whether this fresh leadership, together with the measures recommended in this report, can fix the deep systemic problems caused by split governance.

It is only fair that those Ontarians who live in health units with good governance have the opportunity to see whether the present system can be fixed within a reasonable time frame. But there is too much at stake to let the present problems continue indefinitely. The cost of waiting will be the risk of disease and deaths, so a clear decision point is required. The government must decide whether to continue the present system of split governance, or to upload public health funding and control 100 per cent from the municipalities to the province. That decision needs to be made by the end of 2007, the deadline having been chosen for reasons noted below.

The public health community is deeply divided into those who think the present system of split governance is satisfactory, or at least salvagable, and those convinced by their experience that 100 per cent uploading of funding and control to the province is now the only solution. It will take time to resolve that debate. There is a strong consensus that immediate steps are necessary to strengthen the present system, whatever future direction it might take.

This chapter will:

- Expand on the problems, described in the Commission's first interim report,[69] of split provincial-municipal governance;
- Canvass the arguments for retaining the present system and the arguments for 100 per cent provincial control and funding;
- Note the need for a clear decision on this issue by the end of the year 2007; and
- Note the initiatives undertaken under the fresh leadership of the new Chief Medical Officer of Health to improve the present system.

Pending that decision, five measures are urgently required to improve the existing governance system:

1. Protect the local medical officer of health from bureaucratic encroachment;
2. Require by law the regular monitoring and auditing of local health units;
3. Change the public health programme guidelines to legally enforceable standards;
4. Increase provincial representation on local boards of health and set qualifications for board membership; and
5. Introduce a package of governance standards for local boards of health.

Much of the attention since SARS has been directed towards the provincial level, the Public Health Division of the Ministry of Health and the office of the Chief Medical Officer of Health. While the work and reform that is occurring at the provincial level is vital, it must always be remembered that the first line of defence against disease is in the hands of local health units and medical officers of health. It was they who struggled against SARS in the front lines. It was they who were hampered by the deficiencies in public health resources and infrastructure. As one medical officer of health told the Commission:

> I'm worried that the public health system at municipal level may not be reformed to extent it should be; I think it's being lost in the shuffle. The primary focus for change and reform seems to be at the provincial level. The backbone of the public health system is the local boards of health and they are not getting the proper focus or attention.

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[69] The Commission's first interim report. See in particular Chapter 10 "The Public Health Ping-Pong Game," Chapter 11 "One Local Funding Problem," Chapter 12 "The Municipalities' Funding Dilemma," Chapter 13 "One Local Story: Parry Sound," and Chapter 16 "Greater Priority for Infectious Disease Control."

One thing though is clear: The underlying problems must be fixed or the current system of governance must be radically reorganized. The current state of affairs is unacceptable and cannot continue. Great strides to improve the present system are being taken under the leadership of Dr. Sheela Basrur, appointed since SARS. The first question is whether the province will provide the necessary resources to effect the major changes now planned. The second question is whether local bureaucratic and political resistance will prove too strong. If the province cannot dedicate enough resources and leadership to make the present system work and if the current problems cannot be fixed within the existing system, drastic reorganization is required. Although there may be intermediate solutions, the only solution seriously advanced as an alternative to the present system is to upload the funding and control of public health 100 per cent to the province and to get municipalities out of the public health business.

It would be premature to make such a recommendation, however, without providing some time to see if the system can be fixed within the present framework of governance.

That is why the Commission recommends that the province at the conclusion of the year 2007, which is after the pending public health capacity review,[70] decide whether the present system can be fixed with a reasonable outlay of resources or whether control of public health should be uploaded 100 per cent to the province. This will require an amendment to the "Operation Health Protection" plan to include a firm decision point to upload completely or to leave the present system in place.

The burden of persuasion is on those who want to preserve the present system of split provincial-municipal governance. A clear timeline for that decision is required.

A decision to upload 100 per cent control to the province would in one sense be regrettable because a number of local health units function, under the present system of dual governance, as well as could be expected given current levels of resources. The problem is that viruses do not respect health unit boundaries. The fact that some units function well is no comfort when it just takes one dysfunctional unit to spark a province-wide outbreak of infection. Public health is a provincial programme and every citizen is entitled to an equal measure of protection from infectious disease no matter where they live.

Ontario cannot go back and forth like a squirrel on a road, vacillating between the desire for some measure of local control and the need for uniformly high standards of infectious disease protection throughout the entire province. A clear decision point is required before some deadly infectious disease rolls over the province.

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[70] The Public Health Capacity Review Committee will present interim recommendations to the Ministry of Health and Long-Term Care in June of 2005 and a final report in December 2005. The time for the implementation of its recommendations under Operation Health Protection, is one year from then, the end of 2006. The end of 2007 gives enough time to see whether the reforms are working and to decide whether or not to upload public health 100 per cent to the province.

Unfortunately there is no clear consensus, among municipal politicians or public health officials, on the solution to the problems of split governance. The different views will be canvassed below.

Whatever the ultimate solution to those problems, the following areas clearly require immediate reform and need not await long-range policy decisions on governance:

- First, amend, strengthen and enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health.

- Second, amend s. 7 of the *Health Protection and Promotion Act* to provide that the Minister, on the advice of the Chief Medical Officer of Health shall publish standards for the provision of Mandatory Health Programs and Services and every board of health shall comply with the published standards which shall have the force of regulations.

- Third, amend the *Health Protection and Promotion Act* to require by law the regular monitoring and auditing, including random spot auditing, of local health units to ensure compliance with provincial standards. The results of any such audits should be made public so citizens can keep abreast of the level of performance of their local health unit.

- Fourth, amend the *Health Protection and Promotion Act* to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health.

- Fifth, introduce a package of governance standards for local boards of health.

These measures are in addition to those recommended in the previous chapter of this report to protect the independence of the local medical officer of health and to ensure the direct accountability to that office of those who provide public health services.

Fundamental Governance Problems

The local medical officer of health leading each of the 36 local health units is the backbone of public health in Ontario. However, as was noted in the Commission's first interim report, many medical officers of health report that a considerable amount of their time and energy is spent in turf wars with the municipal bureaucracy and in fighting against budget constraints that prevent the attainment of a proper standard of public health protection.

Since the Commission's first interim report, the Commission has heard additional reports of:

- Municipal officials unilaterally removing or transferring public health staff to other departments within the municipality;
- Municipal officials unilaterally reducing the public health budget, without input from the medical officer of health or the board of health;
- Boards of health with members whose sole objective is to the reduce the budget;
- Boards of health determined to micromanage the health unit instead of performing their role of overall stewardship;
- The inability of the medical officer of health and public health staff to get confidential information technology support and legal advice within the structure of municipal services; and
- The diversion to other municipal departments of funding intended for public health.

This is not to suggest that the above problems occur in each health unit across the province. The Commission has been told of jurisdictions where the board of health works well and has a good relationship with the local medical officer of health. Similarly, not all municipal officials or members of boards of health are against public health funding. Many are in fact very supportive of public health, advocate on behalf of the public and generally take their duties and responsibilities to protect the public's health very seriously.

Unfortunately, experienced and dedicated medical officers of health in other units continue to be demoralized and exhausted by these ongoing struggles. Some of them see little light at the end of the tunnel. As one local medical officer of health described the current state of affairs:

> At a recent meeting of our colleagues, I heard a lot more grief, anger, it was very emotional. People who are close to leaving the profession, who've had it with municipal interference, with the provincial bullying. You need to know, you've got a very shaky public health system, at least with respect to public health physicians.

This local medical officer of health worried about the ability of public health to attract and retain qualified physicians, if they are going to have to face the problems that exist in relation to public health governance:

> I think that on governance and on powers and duties of medical officers of health alone, unless you correct some of these problems, you're going to have a heck of a time trying to attract new medical officers of health when they're put in positions of executive authority but they have to second guess

> the administration, business affairs part of it. And, in fact, they have to deal with boards of health that are not terribly interested in what they're doing.

And the problem may not lie only in attracting new medical officers of health. It also lies in retaining experienced medical officers of health whose frustration is reaching the point of no return:

> I'm absolutely disgusted, I loathe coming to work. I'm hanging on by my fingertips, waiting to see if the system will get fixed soon and if it doesn't, I'm getting out of the public health business.

The deterioration of public health at the local level in some parts of the province is epitomized by the problems recently evidenced in the Scott Report on the dysfunctional Muskoka-Parry Sound Health Unit, discussed below, which led to a decision to abolish the unit and amalgamate it with neighbouring units.

The difficulties of the Muskoka-Parry Sound Health Unit serve as a cautionary illustration of the deep structural problems in our public health system caused by divided provincial and municipal governance. They show how a dysfunctional board of health can impair the effective delivery of public health services. The Commission in the first interim report identified these problems as examples of the weaknesses in Ontario's public health system disclosed by SARS.

On July 12, 2004, Dr. Sheela Basrur, appointed Mr. Graham Scott, Q.C, a former deputy Minister of Health, to conduct an assessment of the Muskoka-Parry Sound Health Unit, pursuant to s. 82(3) of the *Health Protection and Promotion Act*. Although the power to appoint an assessor is assigned by statute to the Minister, he wisely delegated that power to the Chief Medical Officer of Health.[71]

Mr. Scott released his report on October 20, 2004 and on October 21, 2004, Dr. Basrur assumed the powers of the Muskoka-Parry Sound Board of Health.[72]

The Scott Report demonstrated that the local board of health had not functioned properly for years;

> The problems plaguing MPSHU are deeply rooted. The fault lies not with any one individual but with an entrenched governance culture that is focused, not on the delivery of public health programs and their adequacy, but on the

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[71] For the reasons given earlier in this report, the Commission has recommended that this power be reassigned by statute directly to the Chief Medical Officer of Health

[72] The Minister of Health and Long-Term Care granted authority to the Chief Medical Officer of Health to assume the powers of the board of health under s. 86 of the *Health Protection and Promotion Act*. Ministry of Health and Long-Term Care News Release, "Chief Medical Officer of Health takes action to protect health of Muskoka-Parry Sound residents," October 21, 2004. As discussed below, the powers in s. 86 are now given to the Chief Medical Officer of Health.

> cost of public health. Efficient and effective management of the costs of public health is obviously important, but the primary responsibility for the Board is the delivery of public health programs and services to ensure the protection of the residents of the two Districts.
>
> The failure of the Board in not engaging fully in the public health role is overwhelmingly evidenced by the lack of strategic consideration to public health issues and the low regard for the role of the MOH within the MPSHU. Further, the Board, in its attempts to address costs has become a micro-manager of the MPSHU. The Board has no role in management of the MPSHU. Even if it were appropriate for a Board to engage in management, it is an assignment that they are not capable of discharging given their limited experience in public health administration, as well as the other demanding responsibilities that require their time in meeting their responsibilities, particularly those serving as councillors and Mayors.
>
> Indeed the evidence is clear that they failed to bring either sound organization or stability to the MPSHU. This is true even on the administrative and cost side that has been their declared area of priority. On the health side, notwithstanding a previous assessor report, a SARS case in 2003 and the interim report of Justice Campbell, they have not carried out any serious health program or performance review at the Board level, which as a minimum would seem an essential response to critical external reviews.[73]

Mr. Scott summarized what he found in Muskoka-Parry Sound that constituted a dysfunctional board performance:

- The Board had no strategic plan;
- The Board had no process for establishing expectations and monitoring them for either the MOH or themselves;
- The Board did not fully debate or engage on health issues;
- There was no permanent MOH and the Board chose to exercise some of the duties of the MOH;
- The MOH was not invited to and did not report to every Board meeting;
- There was Board micro-management of the Health Unit;
- The Muskoka-Parry Sound Board was focused on expenses and costs not on health policy matters;

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[73] Assessors Report on the Muskoka-Parry Sound Health Unit, Graham W.S. Scott, Q.C., Assessor, October 20, 2004. (Subsequently referred to as the Scott Report.)

- Most Board members paid little attention to the mission of the Health Unit between meetings.[74]

Regrettably, many of the problems identified in the Scott report are not confined to the Muskoka-Parry Sound Health Unit. As one experienced medical officer of health told the Commission:

> … in fact there are shades of Muskoka-Parry Sound in all 37 health units.

Many local medical officers of health who spoke to the Commission reported that post-SARS the battle for independence and resources at the local level has gotten worse.

For example in one public health unit at the end of the first phase of SARS, the local medical officer of health was told by the Chief Administrative Officer that a significant number of staff, currently situated in the health unit and instrumental in the SARS response, were being transferred out of the health unit for consolidation into the municipal bureaucracy. This transfer not only threatened the ability of the medical officer of health to resource the health unit and fulfill the obligations under the *Health Protection and Promotion Act*, but also represented an apparent contravention of s. 67(2) the *Health Protection and Promotion Act*, which gives the local medical officer of health responsibility over employees of boards of health and those whose services are engaged by a board of health if their duties relate to the delivery of public health programmes and services.

Nothing in the *Health Protection and Promotion Act* or the *Municipal Act* authorizes a board of health to delegate its administrative authority to a municipal administrator. Neither the Chief Municipal Administrative Officer nor any other municipal official has any authority to control and manage the staff of a health unit. These are the responsibilities of the medical officer of health. One medical officer of health described the day to day struggle to fight off municipal encroachment:

> Our corporate communications function largely acts as a press secretary for the regional chair. So what if they take over that? What if they take over epidemiology because in fact it is needed in social services and they have not deemed it to be a high priority? I mean how can you fulfill your duties when you do not have the tools at your disposal to make it happen and what can I do as a MOH? I mean I have to go on the QT to outside legal counsel to get this advice because I cannot go to my legal department; they represent two masters …
>
> … I have come to the conclusion that you need to fix governance. I mean that you can strengthen section 67 as much as you want. If you have a counsel or a CAO that just completely ignores it and I am not given any tools or resources to deal with it, then what is the point in having it in the legislation to begin with?

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[74] *Ibid.*

Other medical officers of health cite examples of regional officials making unilateral budget decisions which directly impact on the ability of the medical officer of health to deliver programmes and services legally required under the *Health Protection and Promotion Act*. One medical officer of health described to the Commission how the Chief Administrative Officer for the municipality unilaterally reduced the public health budget, without consultation with the medical officer of health or the chair of the board of health. They simply advised the medical officer of health's staff to reduce the money from the budget.

Other medical officers of health cite examples of board of health members whose priority is budget cutting, rather than health protection and promotion. One expressed the demoralizing effect of that attitude:

> And as a medical officer of health, reporting directly to a board, and I'm speaking now on behalf of medical officers of health, I think the job would be far more appealing if you did have a board that was interested in public health, rather than cutting your budget, freezing your budget, making you beg for all the scraps under the table before they'll give you an increase. It's just demeaning and it's totally dysfunctional. And I can't think of any other setting where you'd be governed by a governing body that's really not interested in what your objects are.

One seasoned medical officer of health thought that the difficulties experienced by many medical officers of health with their local boards and municipalities reflected a cynical municipal political view: if the municipalities made things sufficiently hard for the local medical officers of health, they would encourage the province to take over public health completely and thus free the municipalities from the burden of public health stewardship and expense, and from having to deal with a local medical officer of health who was independent of the municipality.

These difficulties suggest to many that public health in some parts of the province would be better served by removing muncipalities from public health funding and public health delivery. These difficulties have been recognized by the Association of Municipalities of Ontario which advised the Commission before its first interim report:

> The impact and speed at which SARS and West Nile virus spread across jurisdictions points to the vulnerability of the current structures, responsibility, authority and responsiveness of the system – both from a policy perspective and certainly the inappropriateness of subsidizing provincial health programs by the property tax base.

A medical officer of health described a constellation of problems caused by the present governance structure including the difficulty of giving public health its proper priority in a system where those charged with its stewardship may be more interested in diverting money to other municipal purposes than in protecting public health:

> The kinds of individuals that are attracted to, have themselves elected on regional boards are not particularly interested in either health issues or in

> human infrastructure components. And so where there are police boards that are marching in, for example, in our jurisdiction with an enhancement this year, and the regional tax base is looking to absorb that enhancement, if you're in a cross-boarder situation where public security is high on the corporate agenda, it squeezes out services like ours, public health services and really our affinity and alignment is much more with other sectors in our community than the regional corporation… The particular fiscal challenges that we're facing with this year's budget speak, in my mind, to a whole variety of other issues around values, why someone puts themselves forward to be elected, what their passions are. My chair is a good example of a regional corporate thinker who's interested in transit and good infrastructure and the reason he's chair of the public health services board is to get money out of the public health budget. It's not about the protection of the health of the public.

This chapter comes with two warnings.

The first warning is that the Commission attempted no scientific analysis of the opinions of those engaged in public health. The Commission is grateful to the many medical officers of health and others in the public health community who devoted so much time and energy to written submsisions and confidential interviews. The information acquired by the Commission in response to its general request to the public health community was however, because of the nature of the open process of soliciting views, necessarily anecdotal. As noted below, however, even those who want to retain the present system agreed on the need for corrective measures within the present system. And as noted above, it takes only one dysfunctional health unit to bring down the entire province.

The second warning is that the Commission's mandate is SARS and that this report focuses on infectious disease as opposed to other public health concerns such as childhood obesity, heart disease, and other aspects of health promotion.

Whatever might be disclosed by a scientific analysis of public health opinion, the fact remains that there are serious problems in the present system. As noted above, the fact that some health units work as well as is possible is no comfort when it just takes one dysfunctional unit to spark a province-wide outbreak of infection. Public health is a provincial programme and every citizen is entitled to an equal measure of protection from infectious disease no matter where they live.

As noted above and below, pending the resolution of the deep structural problems caused by divided governance, measures must be taken to ensure that the financial priority given to public health, and accountability and authority of the medical officer of health are not diluted by difficulties with municipal bureaucracies.

Should Municipalities Get out of Public Health?

Should split governance between the municipalities and the province be maintained? Should public health be uploaded 100 per cent to the province with no local stewardship? Should some other path of reform be attempted?

The Commission consulted extensively with members of the public health community.[75] There is a clear division of opinion on stewardship. Some feel that public health should be uploaded 100 per cent and controlled by the province. Others feel it is essential to retain the current system or at least some strong aspect of local control and some local funding.

Out of the many possible models for public health governance in Ontario, three basic models[76] have been proposed to the Commission:

- Give the present system another try and see whether a greater measure of central control and guidance, accompanied by the increase in funding from the province can overcome the serious structural problems that flow from divided provincial and municipal stewardship over public health;
- Upload the funding entirely to the province but leave the local municipalities and boards of health some say in local programme delivery;
- Upload the funding entirely to the province, give the province direct control, remove the municipalities from public health stewardship, and abolish the local boards of health.

So long as some measure of local governance remains it is essential to strengthen the present system by the five measures mentioned above:

1. Protect the local medical officer of health from bureaucratic encroachment;
2. Require by law the regular monitoring and auditing of local health units;

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[75] The interviews were conducted on the understanding they were confidential and the participants would not be named in the report although what they said might be reported without personal attribution.

[76] The idea earlier canvassed, of uploading infection control funding and stewardship entirely to the province and leaving the rest of public health under some form of split governance, was not recommended to the Commission during this phase of consultation. The problem with that model is that it maintains all the problems of split governance that flow from the housing of the health unit in a municipal system. In one or two consultations it was suggested that the worst problems arise in the eight or ten regional municipalities under s. 55 of the *Health Protection and Promotion Act* where municipal politicians have more ways to cut public health budgets than exist with independent boards. This view was not unanimous. No one suggested that a model which replaced regional boards with "independent" boards would solve the underlying problems.

3. Change the public health programme guidelines to legally enforceable standards;

4. Increase provincial representation on local boards of health and set qualifications for board membership; and

5. Introduce a package of governance standards for local health boards.

Give the Present System Another Try – Increased Pay for Increased Say

Some argue that the pending increase in the proportion of provincial funding to 75 per cent will make a notable difference. They argue that this, combined with a greater enforcement presence by the Chief Medical Officer of Health, should result in greater central control and less problems around municipal governance.

Others have suggested that the solution may lie in uploading the cost of infectious disease protection 100 per cent to the province and continue with split municipal governance. This would do nothing to fix the difficulties of split governance. This suggestion is not a solution to the underlying structural problem.

While the notion of say for pay should result in the Chief Medical Officer of Health having more input and control over local public health and increasing the proportion of provincial control will go some of the distance to ensuring uniform standards of public health protection across the province, it will not solve all the problems identified above.

The recent difficulties in the Muskoka-Parry Sound Health Unit, described above, serve as a paradigm for many of the problems caused by split governance. While Dr. Basrur's intervention in the Muskoka-Parry Sound Health Unit, and the action in response to Mr. Scott's report, are a good sign that the will is there to address the problems of split governance, the question remains whether there is the will and resources centrally to monitor and control the local systems throughout the entire province and to mediate governance disputes on an ongoing basis.

Since the release of the Walker Report and the release of the Commission's first interim report, the proportion of provincial funding for public health services and programmes has increased.[77] Yet, as noted above, some local medical officers of health continue to report that they face the same problems now that they faced when the municipality paid an equal share of the funding.

As for the recent increase in provincial funding, many local medical officers of health understood that this provincial funding was not to result in a decrease in local funding and not to be used as a form of municipal tax relief. This understanding was based on a memorandum from Dr. Basrur to the medical officers of health, dated December 9, 2004, in which she stated:

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[77] The provincial share of local public health funding rose to 55 per cent on January 1, 2005. It is scheduled to increase to 65 per cent on January 1, 2006, and to 75 per cent on January 1, 2007. (Source: December 9, 2004 memorandum from Chief Medical Officer of Health to medical officers of health and acting medical officers of health)

> As you are aware, the provincial government has made several recent announcements of increased funding for public health programmes and services. This letter is intended to clarify these changes and provincial expectations associated with these increased funds.
>
> New provincial funding is intended to enhance the total funding available for public health in order to improve local public health capacity, and the Province expects municipalities to contribute their full share to this important area of public service. While these provincial initiatives may offer limited financial relief to some local municipalities, the government's primary purpose is providing these funds it to protect and promote the health of the public.

One local medical officer of health described their interpretation of that memorandum, an interpretation that was shared by others:

> The intent of that, which was explained by Dr. Sheela Basrur in the memorandum dated December 9th of this year to MOHs and to chairs of boards of health, was to increase public health capacity across the province. And only in some sort of dire financial situations would it provide some property tax relief for an obligated municipality, that's the sense of her letter.

Some municipalities, however, did not share this view. For example, the City of Toronto considered a plan that would see half of the additional funding go to Parks and Recreation.[78] Councillor John Filion, chair of Toronto's Board of Health, at a budget meeting where the issue was raised, tried to persuade the City to use the money as it was intended: for public health. He was reported as stating:

> I think we're shooting ourselves in the foot if we don't use this money for public health.[79]

Toronto was not alone in its eagerness to use public health money for other programmes. As another medical officer of health reported to the Commission:

> … the base budget has been reduced arbitrarily by the Chief Administrative Officer, without any consultation with me, which will result in a net decrease, or a total decrease in my public health budget for 2005, based on this new funding formula. It will of course mean that we cannot access those cost-sharing funds that would be due to us from the province. So he has

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[78] Toronto Star, "Toronto Could Divert Aid From Province," January 21, 2005

[79] *Ibid.*

> arbitrarily reduced, with in fact not even anything in writing to me, it's simply appeared this way after I'd had my initial budget meeting with him, as a reduction in our base budget and the municipal contribution, which of course goes against the intent of the new funding formula.

Some see the municipal attitude, notwithstanding the provincial attempts to upgrade public health, as a continuing source of opposition to improvement. Said one medical officer of health:

> Things have not improved since SARS notwithstanding the provincial rhetoric of improving public health services because municipal politicians, particularly in regional governments, still see public health as a lower priority than other municipal services such as roads.

The problem is not solely one of funding. The problem is also one of governance. Even if the provincial government uploaded the percentage of provincial funding to 90 per cent, in some municipalities the battle over the remaining 10 per cent and the remaining involvement of the municipality in governance would still lend itself to governance problems and local fights over staff direction, public health communication, and the spending of provincial funds. The problem is not who pays, but who says. Some medical officers of health are convinced that this problem will continue so long as the medical officer of health and local boards of health are embedded in municipal bureaucracies. According to this view, no amount of distant correction, no amendments to the *Health Protection and Promotion Act* can correct the underlying problems facing public health in some municipalities around the province.

Some, however, argue that the combination of increased funding and greater enforcement by the Chief Medical Officer of Health may address the systemic problems. They point to Muskoka-Parry Sound as an example of how the system can work. The situation in Muskoka-Parry Sound cuts both ways. On the one hand, it shows how dysfunctional a public health unit can remain before someone fixes it. On this view it shows that the system is broken. On the other hand, it also shows that the province under new public health leadership has finally taken steps to cure the problem. On this view it shows that the system works. Does one say the system is broken because of the problems or does one say the system works because the province eventually decided to fix Muskoka-Parry Sound Health Unit?

Those who argue that Muskoka-Parry Sound is an example of how the system can work, argue that the province has the tools to ensure compliance with the Act and to ensure a uniform standard of programmes and services across the province. But the system only worked after years of dysfunction, and then only because of the leadership of the new Chief Medical Officer of Health and the Minister of Health. The steps taken in Muskoka-Parry Sound, while admirable, took energy, attention and resources. It cannot be easy for the Chief Medical Officer of Health, amidst all the concern about disease, including pandemic influenza, with myriad pressing daily responsibilities, to confront and wrestle to the ground the local problems caused by the divided stewardship of public health. And Muskoka-Parry Sound was not alone in its problems. It was only the worst and the most obvious. To confront governance problems in a local health unit is to invite political controversy and dispute. Do the Chief Medical Officer of Health and the Public Health Division have enough time, energy and resources to monitor and control local systems, and to mediate governance disputes on an ongoing basis? Is this the best way to use this time, energy and resources? Or is the energy of Ontario's public health leadership best directed to protecting us from disease?

The Argument for Local Control

Those medical officers of health for whom the current system works argue that you should not change the whole system just because some parts are not working. As one medical officer of health stated:

> I don't think you blow up the entire structure because of instances where it didn't work. You put in appropriate checks and balances and carrots and sticks to make the system work.

Some local medical officers of health, concerned about uploading public health entirely to the province, fear that the result will be worse. They fear that the loss of local municipal involvement and contribution will impact their independence and autonomy. They also fear that by relying on an entirely provincial system, you put all your eggs in one basket, and if that system fails to devote the resources to make things work, they will have no other partner to whom they may turn for help. One local medical officer of health said:

> I think there's a concern about too much power being invested in the province. I think the strength, for SARS, Walkerton, whichever, was in the local public health unit response, despite the province. And so, if we centralize too much direction, and then lower the independence of the medical officer of health as well, by uploading it to the province, I have great concerns of that model as well. There's this balance that we have to try and strike between the strength of the local system and ensuring a system overall.
>
> What's going through my mind is, if you didn't have a board of health, then how could you preserve local autonomy and independence without your actions being unduly politicized? If what you mean is a provincial agency, you'd be an employee of that provincial agency. You'd run into the same interference.

Those medical officers of health who oppose provincial uploading position their argument for local stewardship largely in the nature of health promotion work, which depends on local community partnerships with non-governmental organizations, school boards and other local institutions. The argument is that local stewardship strengthens these partnerships, which would be lost or diminished if the province took over public health. As one medical officer of health said:

> … I think it does need to be embedded in the local community boards of health, because public health issues really are at the local level and we're only

> able to move agendas like the smoking by-laws etc. forward through critical mass at local grass roots level so it does need to be part of that milieu but strengthening it is a piece of it and the question is how … I mean police commissions do very well when you look at how they're resourced over time and if you're looking at the public health agenda, you don't do well at the regional corporate table.

But even those who argue for the preservation of local governance, like the medical officer of health quoted above, find it hard to see how public health can get a proper priority within a system of municipal governance.

The problem with 100 per cent provincial control is that in some municipalities the present split governance relationship is welcomed by the medical officer of health. One local medical officer of health, who did not want to see public health uploaded 100 per cent to the province, and clearly had a positive relationship with their board of health and with their municipal councillors, stated:

> I think the local councillors have a voice and people do listen when they speak in the local area. Municipalities and provinces have a link. There is a cross germination that is helpful. When you pay, you pay more attention. Without pay it would be more difficult to get municipal councillors actively involved. When you think about board of health, public health has a history of being local and it is not without good reason. We do need to make sure that we are interacting with local political situations in terms of getting changes made that are supportive and conducive to public health. We need to make sure that we are in step with what is happening locally. Whatever we do, there needs to be a local flavour … I would argue that municipalities are important partners as well.

Another public health official noted the difference between a health issue that impacts all health units in the province, such as infectious disease, and issues unique to the local area such as community based health promotion programmes. The former attracts a greater provincial influence but the latter, it is argued, benefits greatly from local influence:

> I think public health as you know is extremely broad and you know what makes sense perhaps for something like communicable disease control and health protection may have a different balancing in terms of local versus provincial input that is required if you are looking at things that are more community based health promotion. The board of health of course is responsible for the programmes in public health.

One local medical officer of health described the importance of maintaining local boards if balanced by the effective exercise by the province of central control and accountability mechanisms:

> I would favour local boards … but I think that in terms of the makeup of the board of health, you could provide provincial direction in terms of the ideal

> candidates. Maybe the objects of the board of health, whatever. I think that you can design the makeup of the board of health that reflects the community and gives clear direction as to what their role is. I think there needs to be, as I say, a return to the powers and duties of the medical officer of health, certainly at the time that it was downloaded, with a view towards independence at the local level. And in terms of the interfacing with the province, there are lots of instruments there that ensure accountability. You've got programmes, plans and budgets, you've got the mandatory health programmes and services guidelines. You have financial and operating audits. And this happens all the time anyway. And on specific issues, you can deal with the Chief Medical Officer of Health directly. So, I don't worry about sufficient provincial oversight, because I think the instruments are in place now. If you actually look at downloading, though, in terms of compliance with the Mandatory Health Programs and Services Guidelines, I think there has been a trend towards greater compliance, but, for example, the tools that the Province gave themselves with respect to assessment, I think that only kicked in last year. We don't know anything about the results. We don't know if it led to any changes. So, not only are there instruments in place in terms of accountability, quite frankly, the province hasn't exercised the tools that it has at its disposal already to ensure compliance and the carrying out of provincial policy and so forth.

There is no easy solution. For those medical officers of health who enjoy supportive and proactive boards of health, the upload of control to the province may make things worse. For those mired deeply in municipal bureaucracy and day to day struggles with local politicians, the status quo does nothing to address the serious problems they face. One medical officer of health accurately summarized the dilemma:

> One of the challenges I think that you face is the diversity that is out there right now and if you come up with a formula, it is going to make many situations better and some situations worse. For example, [Municipality X] is one of those regional municipalities in which the regional council has elected municipal politicians to serve at the board of health and I think that [Municipality X] would be much better served by an independent board of health with a majority of provincial appointees. In the case of the [Municipality Y], there has been a long history of an extremely progressive group of local politicians. Some members of the board are citizens who are appointed by the municipality but nonetheless are not elected officials themselves and that board has been a leader in terms of public health policy programmes and services. At the time a number of years ago when the board did have provincial appointees, most of them did not distinguish themselves if I can say so there is … so in different jurisdictions, it is going to work better or worse depending on where they are now.

For those whose boards work well it will be difficult to embrace change when that change is accompanied by the fear it will make their local system worse. As one local medical officer of health noted:

> Local medical officers of health are leery of 100 per cent provincial funding. Although they complain about their local boards, the existence of the local board means the medical officer of health is not entirely dependent on the province; they think it's better to stick with the devil they know.

Upload Public Health Funding and Control 100 Per cent to the Province

There has always been a measure of support for the proposition that municipalities should simply get out of the public health business and leave it entirely to the province. Some municipal politicians involved in the "Who Does What" consultations in the mid 1990's were confident that Mr. Crombie would recommend that public health and social services be uploaded 100 per cent to the province. One prominent mayor went so far as to say, of local public health boards, "Don't worry, they'll be gone" only to be jolted by the government decision in 1997 to download public health funding 100 per cent to the municipalities.

It was the unanimous view of all the municipal councillors at a recent regional seminar on public health governance that they should get out of public health altogether. Because the programme direction came so strongly from the province, and the local medical officer of health was independent of the municipality, the municipal politicians felt that municipal influence was just too small having regard to the proportional municipal tax contribution.

While this regional consensus is not a provincial consensus, some observers suggest that it reflects a deep current of municipal opinion in many parts of Ontario.

Even some outside of public health argue the need for uploading public health and ensuring central control under a single governance structure. Mr. Tom Clossen, President and Chief Executive Officer of the University Health Network in Toronto, said this at the Commission's public hearings:

> I think it's a big weakness in the Ontario health care system that public health is under the municipalities. As you might know, public health was put under municipalities as a tax issue, because taxation for education was moved out of the municipalities and into the province was a tax balancing effort. It had nothing to do with what would be the best way to run a health care system.
>
> Again, if you look at other provinces, you'll see that public health is part of the regional health organizations and hospitals, community health, public health, are all under a single governance structure.

Some medical officers of health see a measure of consensus in the public health community for 100 per cent provincial uploading and control. One medical officer of health had no doubt that the greatest consensus was for 100 per cent uploading:

> Q. What is the greatest consensus?

> A. For those of us who have been around it is no doubt upload to the province.

One medical officer of health responded to a suggestion that the public health community was generally against a 100 per cent upload of provincial control because of the fear that it would result in the loss of local uniqueness and the ability to deal with local problems:

> I totally disagree. I have never had a local person interested in local health issues. I think it should be uploaded 100 per cent … Medical officers of health do like to be independent but some want to have their cake and eat it too … I would much rather have a functioning provincial system with accountability. It used to be done that the province would come and say you are not doing this well or not focusing on this – or they would say we think your demographics are changing and you need to adjust your programmes. There are mandatory programmes for a reason.

Some observers fail to see how community partnerships depend on municipal funding and the involvement of municipal politicians in health board stewardship:

> The thrust of their [those who oppose full provincial control] argument is that the grass roots of health promotion are at the municipal level. But the partnership isn't with the municipal councillors, it's with the community partners, schools, school boards, long-term care facilities, and so forth. I don't know why they think that 100 per cent provincial funding would mean no local community partnerships … It's not the councillors with whom we have partnerships but the staff at the municipal level. For many boards, the only role of municipal councillors is to have input into health to control funding.

Those who favoured full provincial uploading agreed that local health promotion programmes require strong community links. But they thought the continuation of community links had nothing to do with the question of municipal governance. They noted that the important community involvement was not with municipal councils or politicians, but with schools, school boards, long-term care facilities, and other community partners. In their view the strength of these community relationships came not from the political link with the municipalities, but from the work of the medical officer of health and health unit staff in the development of community links.

One public health observer struck a chord with the suggestion that the local municipal link was a political wild card without any consistent benefit throughout the province:

> There's a disconnect here, between the importance of the role of the medical officer of health and bringing in a group of political appointments, Order in Council this, Order in Council that, depends on who the government is, to be your governing body in some way or to give you advice, when in fact, if you get the right person in as the medical officer of health, and you do that across the province, you have direct access to the people who make the

> decisions about where the money goes. And, to my mind, I can't see taking the chance that with those in power in your jurisdiction, you're going to have enough people that are favourable with the government in power, to give you clout when it comes to negotiating, as opposed to the next jurisdiction or somebody in another part of the province who has the real ace card when it comes to this. It seems to me, you can be the local medical officer of health, but you can also be part of a provincial system and derive great benefits from that, without having to rely on this questionable system that brings you only advocacy, depending on whether you've got the right group of people or not, and maybe some outreach, which I imagine you could get in other ways.

There are many ways to retain local decision-making and community participation without the existing structure of municipal funding and political involvement. The public partnerships so vital to local health promotion, as noted above, are not with municipal councillors or politicians. They are with schools, school boards, health care institutions, and voluntary organizations. Full tax uploading and full provincial control is perfectly consistent with the continuation of such partnerships. Many Ontario ministries maintain strong local links through advisory groups and community outreach. Local community participation in provincial programmes does not require split provincial-municipal governance.

If one accepts the principle of "say for pay", a principle the Commission notes is endorsed by the Association of Municipalities of Ontario,[80] then the government that pays for the programme says how it will be run. Many who advocate 100 per cent provincial pay see the result as 100 per cent provincial say with no municipal governance and no problems from the municipal level.

Others want it both ways. Some who strongly favour local decision-making argue that it is possible to upload the funding 100 per cent to the province yet retain the present municipal stewardship through local boards of health. On this highly political question the Commission can do no more than point out the difficulties of any such departure from the principle of political accountability for the expenditure of public funds, and agree with the observation of the experienced public health observer, quoted above, that

> Say will be hard without pay.

Because public health is a provincial programme and because the divided accountability between the province and the municipalities works very poorly in some parts of the province, a strong argument can be made for 100 per cent provincial uploading and control. It would be premature to recommend this permanent change in governance in this interim report. Full provincial uploading would have significant tax implications, as shown by the tortured history of provincial and municipal cost sharing[81] and big human resource issues caused by the change of employer. Transition to full provincial funding and control would require enormous administrative adjustments even beyond those within the present scope of the Public Health Capacity Review Committee.[82]

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[80] AMO Report to Members: Recent MOU Meeting with Province, February 18, 2005, Alert 05/016.

[81] Described in the Commission's first interim report under the heading "The Public Health Ping-Pong Game."

Full provincial uploading would also require a long-term commitment to refrain from further downloading. Unfortunately, as noted in the Commission's first interim report, Chapter 10, The Public Health Ping-Pong Game, the local public health units have long suffered the impact of consistent provincial downloading to the municipalities that occurred in the late 1990's. A public health scholar noted recently that the funding crisis has not so much been a ping-pong game, but rather a series of pings, followed by a big pong, then further pings.[83]

> The history of provincial funding of local public health is not a ping pong game, unless the focus is on a very short period (e.g., 1997 - 1999). The secular trend is one of increasing provincial financial support, both to more local units and to a larger local units at a higher level of support, beginning in 1940 and continuing consistently until the 1997 decision (effective Jan 1 1998) to download 100% of public health costs to the local level … Mr. Justice Archie Campbell identified 23 problems that contributed to or exacerbated the 2003 SARS crisis in Toronto. Many of them have to do with public health, particularly the dismal state of public health at the provincial

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[82] Chaired by Dr. Susan Tamblyn, former medical officer of health for the Perth District Health Unit, the Capacity Review Committee is to advise the Chief Medical Officer of Health on the following:

- Core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer);

- Issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);

- Identifying operational, governance and systemic issues that may impede the delivery of public health programmes and services;

- Mechanisms to improve systems and programmatic and financial accountability;

- Strengthening compliance with the *Health Protection and Promotion Act*, associated Regulations and the Mandatory Health Programs and Services Guidelines;

- Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.

[83] Ping reflecting an uploading of funds to the province, a pong indicating a download of funds to the local level. See: "Comparative Historical Perspective, Mr. Justice Archie Campbell's Ping Pong Game," Mary Powell, PhD, Visiting Scholar, Comparative Program in Health and Society. Munk Centre, University of Toronto.

> level. If we take a historical view, dismal has been the norm for public health.[84]

The question raised above as to whether the Public Health Division has the resources and appetite to oversee the local health units and boards of health so as to ensure compliance with the Act, and to enforce the Act in the face of a recalcitrant or ineffective board of health or where a municipality or municipal council interferes with the delivery of public health services, is an important one. Equally important, however, is whether the provincial government has the commitment to upload public health funding for the long term, or will it be a ping followed years from now with another great pong? And will the provincial government dedicate the resources to ensuring that the Public Health Division is capable for assuming the governance of 36 boards of health across the province.

Association Of Municipalities' Position

The Commission's first interim report noted the Association of Municipalities of Ontario's position in respect of municipal funding of public health. During the preparation of this second interim report the Commission repeatedly asked the Association of Municipalities of Ontario for its assistance and position on a number of the issues addressed in this report, including the continuation of local public health governance. The Association of Municipalities of Ontario unfortunately found itself unable to take a position.

Local Health Integrated Networks

Before leaving the question of public health governance, a word should be said about the proposed Local Health Integration Networks (LHINs). Announced on July 14, 2004, LHINs are intended to re-align the planning and delivery of health services across Ontario through 14 geographically based networks.

Whatever promise the Local Health Integrated Networks may hold for the hospital system and the health system in general, the Local Health Integrated Networks proposals to date make little if any reference to the alignment between LHINs and public health units.

It is difficult to find anyone who says that LHINs will be good for public health. One hospital administrator at a recent conference on Local Health Integrated Networks said:

> There's nothing for public health in the LHIN's.

The Ministry of Health and Long-Term Care describes their purpose in the following terms:

> LHINs are organized geographically to bring health services closer to where people live. Accordingly, geography is a central organizing principle underlying the LHINs. The 14 Local Health Integration Network areas were created to reflect local areas where people naturally seek health care. They

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[84] *Ibid.*

> were determined by using an evidence-based methodology in collaboration with the Institute for Clinical Evaluative Science (ICES). The boundaries are permeable and do not restrict patient choice of physician and medical or acute services.
>
> Local Health Integration Networks will integrate health care at a local level and consolidate the following functions: planning, system integration and service coordination, funding allocation, and evaluation of performance through accountability agreements. The first function that the LHINs will be expected to take on is integrated health services planning, which will help inform and shape the design and execution of the other functions.[85]

Governance of LHINs will be through an appointed Board of Directors and through performance agreements with the Ministry:

> The Boards will be appointed by an Order in Council. Board members will be selected using a merit-based process, with all candidates assessed for fit between skills and abilities of the prospective appointee and the needs of each individual LHIN. The appointment process will be transparent and consistent – with clear and understandable guidelines applied consistently to all Board appointments.
>
> Board members will be expected to possess relevant expertise, experience, leadership skills, and have an understanding of local health issues, needs and priorities.[86]

Some close observers of the public health scene speculate that health unit boundaries will eventually be aligned with Local Health Integrated Network boundaries,[87] especially given the terms of reference of the Capacity Review Committee, chaired by Dr. Susan Tamblyn, former medical officer of health of the Perth District Health Unit. Among other issues, the Capacity Review Committee will examine:

> Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks,

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[85] Ministry of Health and Long-Term Care, "Taking Stock: Setting Integration Priorities – A tool to guide the initial LHIN transformation process," p. 2.

[86] Local Health Integration Networks, "Bulletin No. 5 / December 15, 2004."

[87] It is worth noting that, in the midst of implementing LHINS, the issue of reducing the number of local units appears to have fallen off the radar screen. As stated in the Commission's first interim report (see pages 190-191), the Walker Interim Report had recommended that the existing number of public health units should be reviewed and, within two years, reduced from 36 units to 20 to 25 units. Some observers questioned whether it is necessary to reduce the number of local units instead of providing the necessary critical mass of expertise to serve a number of individual units, on the argument that the problem is not the number of local units, but the lack of support and resources made available to the local units.

> primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.[88]

However it is undertaken, any decision to align public health units with LHINs will prove to be complex. The City of Toronto, for example, will have four of the 14 LHINs within its geographic boundaries, although only one will be entirely in the City. A report to City Council stated:

> The only one that falls entirely within the City of Toronto municipal boundaries is Toronto Central. This LHIN encompasses seven high volume hospitals, namely Mount Sinai, Hospital for Sick Children, University Health Network, Sunnybrook, St. Joseph's, St. Michael's and Toronto East General. The Central East LHIN includes Rouge Valley and Scarborough General. The Central LHIN includes North York General and Humber River. Last, the Central West LHIN will include both William Osler sites, including Etobicoke.[89]

Thus, three of the four LHINs in the City will be jointly served by Toronto Public Health and by neighbouring public health units, each of which may do some things differently. As Dr. Bonnie Henry told the Justice Policy Committee, boundaries are already creating coordination problems among some Toronto area public health units:

> … we have 22 hospital corporations in the City of Toronto. Many of them have sites outside the City of Toronto. The Rouge Valley Health System has two in Toronto and three outside of Toronto. If we are doing things differently in two different health units, that can be very difficult for a hospital. It's the same if we look at our mental health system, our community care access centres, our district health councils, our long-term-care facilities. They are all, if you want, regionalized or organized on different geographical and jurisdictional boundaries. That can create massive difficulties in dealing with an emergency, and it's not limited to the health sector. It's similar in many other parts of our organization as well. For example, one health unit may actually involve several different municipal police services plus the OPP.[90]

Having regard to the absence of information on public health and LHINS, it is beyond the ability of this report to review and assess the plusses and minuses of transferring local public health into regional networks like LHINS. Nevertheless it is clear that such a transformation would by its very nature be complex and unsettling.

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[88] Public Health Capacity Review Committee, Terms of Reference.

[89] City of Toronto Council, "Consolidated Clause in Community Services Committee Report 8, which was considered by City Council on November 30, December 1 and 2, 2004," p. 3.

[90] Justice Policy Committee, Public Hearings, August 18, 2004, p. 153.

Significantly, it also may generate important stresses and pressures on public health. Were this transformation to occur in the near term before measures to strengthen public health have taken hold, a process that may take years,[91] it would likely add to the considerable strain already felt by a public health system struggling to cope with the deep-seated problems caused by years of government inattention and neglect.

It is too early to tell what LHIN's mean for public health. The LHIN documentation and literature makes little if any reference to public health. The significant questions have not been answered: will the LHIN boundaries affect public health boundaries? If so, how? How will LHIN's governance mesh, if at all, with public health governance? Will LHIN financial and resource planning affect the delivery of public health services? If so, how? These questions far from being answered, do not appear even to have been addressed. The proposed LHIN system, announced as a major transfiguration of Ontario's health system, appears to ignore public health. The LHIN proposals, from the public health point of view, are a complete wild card.

Conclusion on Uploading

As noted above, Ontario's protection against infectious disease is only as strong as the weakest public health unit in the province. An outbreak of disease that spins out of control in a dysfunctional health unit can spread to other units and bring the province to its knees within days. Although machinery does exist for provincial oversight of individual health units, the process is unnecessarily cumbersome. The complex procedures for statutory oversight of local health boards take time and energy, distracting the Chief Medical Officer of Health from the more vital task of protecting the public health rather than dealing with intransigent local boards. It is hoped that the recommendations set out below will overcome some of these difficulties.

As for the workability of the present municipal stewardship system, there will be as many different points of view as there are health units. In well functioning local health units people will argue for the virtues of local stewardship. In dysfunctional local health units, or those where the only apparent municipal interest is to cut cost at the expense of public health, those who care about public health will argue that the present system is broken and cannot be fixed.

The province has powers under the *Health Protection and Promotion Act* which enable it to monitor and correct deficiencies in local health units. Although these powers may need to be fine-tuned, the bigger question is whether the province has an appetite to take hold of the local public health system and confront those who need to be confronted in order to make the system work. It may be that the powers of provincial oversight have been exercised unevenly over the years and that some local medical officers of health have felt unsupported by the province in the struggle to maintain the integrity and political independence of the office of medical officer of health in the face of unfriendly local power structures. The key question at this time is, does the province have the appetite and the resources to oversee municipal stewardship?

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[91] The U.S. General Accounting Office, the equivalent of the Auditor General of Canada, in underlining the challenge of making fundamental, long-term change, has stated: "Experience shows that successful major change management initiatives in large private and public sector organizations can often take at least 5 to 7 years. This length of time and the frequent turnover of political leadership in the federal government have often made it difficult to obtain the sustained and inspired attention to make needed changes." (Source: U.S. General Accounting Office, *Centres for Disease Control and Prevention: Agency Leadership Taking Steps to Improve Management and Planning, but Challenges Remain* (Washington, D.C.: January 2004), pp. 2-3.)

It is too early to say the system is hopeless. But the burden of persuasion has fallen to those who want to make the present system work. Is the government prepared to pour into the present system the resources necessary to make it work? Is it prepared to devote the energy, leadership and political will necessary to make it work? If the province does not commit the necessary resources, and develop the will to wrestle the present system of split stewardship into a consistently excellent province wide system of governance, then it should withdraw municipalities from the field. It is infinitely more efficient, and saves infinite time, energy, and resources to administer a unitary stewardship system. It takes enormous work to make a mixed stewardship system work and the question must be asked, is it worth it?

The important question that must be resolved is whether the present system can be fixed and at what cost in resources and focus. The cost of failing to fix it is risk of disease and death … should an infectious outbreak strike a health unit that is poorly resourced, poorly prepared, and struggling to breathe within the municipal bureaucracy.

There is no doubt that municipal stewardship works well in some areas and poorly in others. The challenge is to identify the conditions that make the difference between the good and the bad, and to fix the latter.

Although it may be that the conditions that drive the difference have to do with size and demography, the anecdotal evidence examined by the Commission suggests otherwise. It appears, anecdotally, that large urban health units and small rural health units can be equally successful or unsuccessful depending on a host of factors other than size and demography. The conditions that make a difference are many, including local history and tradition, the organizational culture of the local board and health unit, the personality of the local medical officer of health, board members and politicians, and the cyclical determination and ability of the province, waxing and waning over the years, to do what is necessary to make the local systems work.

One condition that makes for good governance is the adoption of governance standards of the kind recommended below.

The fact that many public health units work in an admirable fashion is a credit to the individuals involved, not to any wisdom in the institutional arrangment that leaves a provincial function like public health in the hands of local municipalities. In some local units the management of the difficult relationship between the medical officer of health and the board and municipal authorities diverts precious time and energy from the real task of protecting the public against disease. In some cases the difficulty of ensuring local municipal compliance diverts more time and energy from the first priority of the Chief Medical Officer of Health and the province, which should be public health protection rather than mediation with local governments and boards.

All the fine public health initiatives taken since SARS, all the fine initiatives planned and considered for the future, are at risk from the deep problems that attend the municipal role in the delivery of provincial public health services. One dysfunctional health unit can break the chain of protection.

The issues surrounding the municipal governance of public health are complex. As set out above, there is no easy answer and there is no common solution. However as one local medical officer of health aptly noted, there is plenty of fuel for the discussion. The discussion has to occur now, and a timeline for decision-making and change must be set.

To this end, as noted in the introduction to this chapter, the Commission recommends that the province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review,[92] decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 per cent to the province. This will require an amendment to the Operation Health Protection plan to include a firm decision point to upload completely or to leave the present system in place. The take-home message here is that the burden of persuasion is on those who want to preserve the present system of split provincial-municipal governance. A clear timeline for that decision is required.

The underlying problems of municipal funding and municipal governance are the Achilles heel of public health in Ontario. Ontario's only choice, if these problems cannot be fixed within a reasonable time, is to assume full funding and direct control of public health in Ontario.

This recommendation might be resisted on the grounds that the system is going through enough changes right now without the further distraction of a fundamental review. But if a timetable is not set now to resolve this fundamental issue it will continue to fester for years as it has in the past, to the detriment of the morale of those who serve the system with such dedication and to the detriment of the public interest in public health protection. The risk of inaction is simply too high.

Recommendation

The Commission therefore recommends that:

- **The province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review, decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 per cent to the province.**

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[92] As noted above, the Capacity Review Committee is to present its final report in December 2005.

Municipal Bureaucracies

In some municipalities, public health faces a constant flow of problems that impact their ability to deliver health services and to protect the public. These problems include:

- Local health units with unfilled full-time medical officer of health positions;[93]
- Local health units without adequate staff;
- Medical officers of health without operational control over what staff they do have;
- Constant warfare and turf disputes between the municipal authorities and the medical officer of health; and
- Municipal reluctance to authorize payments required by law to meet minimum health protection standards laid down in the Mandatory Guidelines.

These problems have led to uneven levels of functionality in health units around the province, some strong and others weak. In those areas plagued by these problems, the local medical officer of health and public health staff have done an admirable job trying to protect the public, while struggling daily for operational and administrative control, and to secure appropriate levels of funding. It is a testament to their professionalism and dedication that in the face of these problems they remain in the service of the public, committed to protecting the public.

On the other hand, not every board of health is dysfunctional. Some, as noted above, function quite well. Not every municipal official or board of health member is against public health. Some, as noted above, are very proactive and they provide a supportive voice and, indeed, advocacy on behalf of the public's health.

Although there is no consensus on the ultimate solution to the problem of the dual system of governance, there is some common ground. The common ground is that so long as the governance of public health remains at the local level, the province, through auditing, enforcement and amendments to strengthen the *Health Protection and Promotion Act*, must ensure that local medical officers of health are free to do the important job of protecting the public.

Too much energy goes into the conflict between municipal funding concerns and the needs of public health. Too much energy goes into the mediation of disputes arising from the municipal role. A medical officer of health in one of Ontario's largest cities described the problem to the Commission:

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[93] As of October 21, 2004, there were two full-time vacancies in the province: Hastings County and Peel. Additionally, six medical officers of health positions were filled on an acting basis (information provided by the Association of Local Public Health Agencies).

> Most of us are lost deep down in municipal bureaucracies. This needs to be corrected. The medical officer of health should be the Chief Executive Officer of a distinct service unit with accountability to a Board.

Despite the existence of s. 67(2), which should provide the medical officer of health with clear authority over and responsibility for public health employees as noted above, in some municipalities local medical officers of health are struggling to keep their staff, much less direct them.

Subsection 67(2) provides:

> The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programmes or services under this or any other Act.

This provision is designed to ensure that the Chief Medical Officer of Health has the necessary authority and accountability in respect of staff and resources of the board of health.[94] Section 67 looks on its face like a common sense provision with which every sensible person would agree. It has, however, become in some health units a battleground between local medical officers of health, who attempt to preserve the administrative integrity of public health resources, and muncipal authorities determined to extend their control at the expense of public health. More will be said below about this problem in the context of s. 67.

As noted above, in Muskoka-Parry Sound, Mr. Scott observed that:

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[94] The entire section provides as follows:

> Medical officer of health
>
> 67 (1) The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programmes and services under this or any other Act.
>
> Direction of staff
>
> (2) The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programmes or services under this or any other Act.
>
> Management
>
> (3) The medical officer of health of a board of health is responsible to the board for the management of the public health programmes and services under this or any other Act.

> … the Board, in its attempts to address costs has become a micro-manager of the MPSHU. The Board has no role in management of the MPSHU.

The problems faced by some local medical officers of health and the situation in Muskoka-Parry Sound Health Unit suggest that s. 67 has not prevented the apprehended danger that public health administration would become lost within the municipal bureaucracies.

The Commission in its first interim report analyzed serious problems at the local level and recommended:

> Whatever is done by way of structural revision, two adjustments are clearly needed to the role of the local medical officer of health. The first is to ensure, as noted above, that the local medical officer of health enjoys the same degree of political independence from the local power structure that the Chief Medical Officer of Health enjoys from the province. Both the local medical officer of health and the Chief Medical Officer of Health require the ability to speak out on public health issues without going through a political filter, and need to manage outbreaks free from politically motivated interference. The second is to ensure that the local medical officer of health is not buried in the municipal bureaucracy. It has been suggested that some local medical officers of health, as municipalities moved to consolidate, have been sucked into the corporate municipal entity instead of retaining the executive authority over their own operations that is necessary to ensure their accountability for the administrative machinery that makes public health work on the ground.

The first recommendation, ensuring the independence of the local medical officer of health, is discussed in the previous chapter, Medical Independence and Leadership.

Following the above passage in the first interim report, the Commission recommended that s. 67 be enforced, or if necessary, amended:

> Because of the overall provincial interest in public health protection and because of the statutory obligations of the local medical officer of health to ensure public health protection, the provisions of s. 67 should be enforced or if necessary amended to ensure that the medical officer of health has direct administrative control over the personnel and administrative machinery required to deliver public health protection.

Mr. Scott, in a presentation to the Grey-Bruce Board of Health, set out the important distinction between the CEO/Board relationship in most corporations, and the medical officer of health/board relationship in the *Health Protection and Promotion Act*:

> While the Board is ultimately responsible for the quality and success of the mandatory health programs and in the execution of the above duties, the relationship with the Medical Officer of Health ("MOH") is central to the success of the health unit.

> The foregoing makes it plain that there is a marked difference between CEO/Board relationship in most corporations and the MOH/Board relationship under the HPPA.
>
> The Board, subject to the approval of the Minister, has the responsibility to hire and fire the MOH, assess the MOH, and hold the MOH accountable for the effective operation of the health unit. This on the surface is similar to the Board/CEO relationship in other corporations. However, in other corporations the Board can interfere with the CEO and remove the CEO at will and even take over the operation of the corporation. This is not an option under the HPPA.
>
> In addition to the substantial medical powers carried by the MOH, the MOH must also ensure the development of a budget that is sufficient to meet the public health needs while administering a health unit that is efficient, and cost effective. The board must approve the budget. This leadership by the MOH in both medical and administrative matters and the policy and approval oversight by the Board should provide assurance that the public health is protected and that public health programs are delivered at a reasonable cost to their taxpayers.
>
> The failure to understand these dynamics and the central role of the MOH was at the root of most of the problems in Muskoka-Parry Sound. The board seemed to believe it could act as it saw fit with the office of the MOH. They were wrong in policy and wrong in law![95]

In some areas there is a clear lack of understanding of the role of the board of health. This is evidenced by the numerous examples of municipal officials, both those who sit on boards of health and those who aren't members of the board of health, virtually ignoring s. 67. Those examples, along with the Muskoka-Parry Sound experience, demonstrate that s. 67 as it now stands is powerless against any municipality or local board that chooses to ignore or defy it.[96] Section 67 in its present form has proved inadequate to prevent the mischief it was designed to prevent.

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[95] Graham W.S. Scott, Q.C., Presentation to the Grey-Bruce Board of Health: Critical Elements for Effective Governance of Boards of Health in Ontario, January 21, 2005. (Subsequently referred to as the Scott Presentation.)

[96] This is clear from the Scott Report findings:

> … I am satisfied that the Board has shown little interest in meeting the requirements of the legislation where it is inconvenient. For example:
>
> 1) The Board has been without a full-time MOH for most of the time since 2000 and consequently has not met the requirements of Section 62(1) of the HPPA, which require it to appoint a full-time MOH.

The overall provincial interest in public health protection, and the statutory obligations of the local medical officer of health to ensure public health protection, require the amendment of s. 67 to ensure that the medical officer of health has direct administrative control over the personnel and administrative machinery required to deliver public health protection.

The Commission therefore again recommends that s. 67 be amended and strengthened to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials. More importantly, however, as will be discussed below, so long as public health governance remains at the local level, the provincial government must be vigilant in auditing and taking decisive action where violations of s. 67 occur.

A parallel amendment is required to provide that the local medical officer of health is the chief executive officer of the local board of health. It must be made abundantly clear that the local medical officer of health has exclusive authority over the direction of employees whose duties relate to the delivery of public health programmes and services. It must be clear that the local medical officer of health is responsible to the board for the management and administration of public health programmes and services, and the business affairs of the board of health.

This measure, among others, is necessary to ensure that local medical officers of health have the clear authority to manage the health unit and that appropriate public health standards are met across the province. So long as municipally governed local boards remain in place, the local medical officer of health requires both full authority, as chief executive officer in respect of local public health services, and direct accountability to the local board free from any municipal intervention.

As noted in the previous section, the medical officer of health requires a degree of independence parallel to that now provided to the Chief Medical Officer of Health. Medical officers of health should have the duty and the authority to speak out publically about local public health concerns. This must include the power to bring to the attention of the public a local board's failure or refusal to comply with their obligations under the Act. The local medical officer of health must be able to do so without fear of recrimination, reprisal,

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2) The last time an MOH reported regularly to the Board was during the tenure of Dr. Pfaff. The Board has, at best, been passive about the presence of the MOH at Board meetings and is clearly outside the intent of Section 67(1) of the HPPA.

3) The Board's actions with regard to personnel matters have circumvented and frustrated the intent of Section 67(2) and (3) which provide that employees are subject to the direction of, and responsible to, the MOH.

4) The Board has, by procedural means, made it difficult for the MOH to exercise the right in Section 70 to attend each meeting of the Board and every committee meeting.

5) The Board has appointed Co-Chairs of the Board notwithstanding that they were aware that the HPPA has no provision that permits the appointment of Co-Chairs.

dismissal, or other adverse employment consqequences. The Commission reiterates its recommendation in the previous section that the *Health Protection and Promotion Act* must be amended to provide every local medical officer of health with a degree of independence parallel to that recommended for the Chief Medical Officer of Health, including the duty and authority to speak out publicly about local public health concerns without fear of adverse employment consequences.

Recommendations

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health. In particular, the Ministry of Health and Long-Term Care should:**
    - **Amend and strengthen s. 67 of the *Health Protection and Promotion Act* to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials;**
    - **Take enforcement actions in respect of violations of s. 67;**
    - **Amend the *Health Protection and Promotion Act* to clearly state that the medical officer of health is the chief executive officer of the board of health; and**
    - **Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence parallel to that of the Chief Medical Officer of Health, as set out in Chapter 1 of this Report.**

Strengthening Accountability

SARS showed that provincial control over public health protection needs more teeth.

The present regime depends on compliance by local public health boards with the Mandatory Health Programs and Services Guidelines (the Guidelines). First published in 1984, and then revised in 1997, the Guidelines set out minimum requirements for public health programmes and services delivered by public health units across Ontario.

Although the statute requires local boards to comply with the Guidelines, a guideline is no more than a suggestion, making the Guidelines a weaker form of direction than standards. A uniform standard of health protection throughout the province requires more than a series of suggestions that are inadequately monitored, audited and enforced.

Under the *Health Protection and Promotion Act*, every board of health is responsible for ensuring the provision of health programmes and services required under the Act and its regulations. Section 4 of the *Health Protection and Promotion Act* provides:

> 4. Every board of health,
>
> (a) shall superintend, provide or ensure the provision of the health programs and services required by this Act and the regulations to the persons who reside in the health unit served by the board; and
>
> (b) shall perform such other functions as are required by or under this or any other Act.

Section 5 of the Act sets out the types of health programmes and services that every board of health must provide:

> 5. Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:
>
> 1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
>
> 2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
>
> 3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases.
>
> 4. Family health, including,
>
> i. counselling services,
>
> ii. family planning services,
>
> iii. health services to infants, pregnant women in high risk health categories and the elderly,
>
> iv. preschool and school health services, including dental services,
>
> v. screening programs to reduce the morbidity and mortality of disease,

> vi. tobacco use prevention programs, and
>
> vii. nutrition services.
>
> 4.1 Collection and analysis of epidemiological data.
>
> 4.2 Such additional health programs and services as are prescribed by the regulations.
>
> 5. Home care services that are insured services under the *Health Insurance Act*, including services to the acutely ill and the chronically ill.

While s. 5 sets out the general areas, it does not establish a baseline standard of service that must be provided in each area. Rather, this is set out in the Guidelines established by the Minister under the authority of s. 7 of the *Health Protection and Promotion Act,* which provides:

> 7. The Minister may publish guidelines for the provision of mandatory health program and services and every board of health shall comply with the published guidelines.

As the opening paragraph (see below) of the Guidelines demonstrates, the words "guideline" and "standard" are used interchangeably, as if they had the same meaning and same mandatory vigor:

> The standards contained in this document obtain their legal authority under provisions of the *Health Protection and Promotion Act.* Part II, Section 5, of the *Health Protection and Promotion Act* specifies that boards of health (as defined in the *Health Protection and Promotion Act*) must provide or ensure the provision of a minimum level of public health programs and services in specified areas. Section 7 of the *Health Protection and Promotion Act* authorizes the Minister of Health to develop and publish guidelines that represent minimum standards for these programs and services.

However, guidelines are weaker than standards.

The Canadian Oxford Dictionary defines "guideline" as:

> A principle or criterion guiding or directing action.

But it defines "standard" as prescriptive in nature:

> An object or quality or measure serving as a basis or example or principle to which others conform or should conform or by which the accuracy or quality of others is judged.

Merriam-Webster's Dictionary of Law defines "standard" as:

> Something established by authority, custom, or general consent as a model, example, or point of reference.

Stedman's Online Medical Dictionary defines "standard" as:

> Something that serves as a basis for comparison; a technical specification or written report by experts.

Although to some the difference between the words "guideline" and "standard" may be a matter of linguistics, to others the term "standard" more appropriately reflects their significance and mandatory nature. As one experienced medical officer of health told the Commission:

> It would be very helpful even if you just changed the name because in fact they are … if you read the details they are legally enforceable but you would not think so from the description.

Although this observer thought the Guidelines were legally enforceable, it is difficult to identify any quick and effective legal machinery for their enforcement under the present system.

The term "guideline" connotes discretion and suggests that a particular level of performance is desired but not required. A guideline is simply an indication or outline of policy or conduct; a mere suggestion. Mere suggestions are not enough to ensure a reasonable level of public health protection across the province. It is not enough to require boards of health to meet guidelines. Standards are stronger, requiring a particular level of performance. The measures required to protect public health should be laid down as binding standards across the province, having the force of law and with consequences for noncompliance.

The Commission welcomes the decision of Dr. Basrur to review the Mandatory Health Programs and Services Guidelines, a process that,

> … will incorporate emerging health issues, best practices, new science, as well as lessons learned from Ontario's experiences with Walkerton, West Nile virus and SARS.[97]

Many public health advocates have recommended to the Commission that the standards be included as part of the regulations to the *Health Protection and Promotion Act*, to give them the strength of law. This makes good sense in order to ensure that the standards have the force of law. As one medical officer of health told the Commission:

> I recommend that the guidelines be replaced as a standard. I recommend that they be given the weight and laws of regulations …

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[97] Public Health Division, "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs," (Toronto: February 2005), p. 3

Recommendation

The Commission therefore recommends that:

- **Section 7 of the *Health Protection and Promotion Act* be amended to provide that the Minister, on the advice of the Chief Medical Officer of Health, shall publish standards for the provision of mandatory health programmes and services, and every board of health shall comply with the published standards that shall have the force of regulations.**

Monitoring, Auditing and Enforcement

Compliance is weak in any system when standards are considered to be mere suggestions whose observance is discretionary. Compliance declines gravely in any system when standards are perceived to lack the weight of mandatory direction and are not effectively monitored, audited or enforced. Under such conditions, even the best-crafted standard can fall short of its intended goal.

Effective monitoring, auditing and enforcement can help to root out organizational problems before they spin out of control and require drastic measures. They can raise the level of performance among weaker health units. And they can ensure the provision of a uniform level of public health services throughout Ontario.

Ineffective monitoring, auditing and enforcement, as demonstrated by SARS, can allow problems of capacity, resources and leadership to fester and worsen. Weak health units are permitted to decline even further. Ineffective central control deprives Ontarians of their right to expect similar levels of public health protection no matter where they live.

Prior to SARS, the Ministry had a poor track record of monitoring local health unit compliance with the Guidelines. The Provincial Auditor (now the Auditor General) stated in his 2003 report:

> Ministry staff informed us that, since 1998, only one assessment of a local health unit had been undertaken and that in March 2003, the Ministry began limited assessments of mandatory programme areas at five local health units.
>
> When the Guidelines were revised in 1997, the Ministry estimated that it would take three years to achieve full compliance. In 1998, the Ministry initiated an annual Mandatory Programs Indicator Questionnaire (MPIQ), whereby local health units answered a series of questions related to the Guidelines. The Ministry uses their answers to assess whether programme requirements are being met. At the time of our audit, the Ministry was in the process of reviewing the MPIQs covering the year 2001.
>
> We questioned the Ministry's full reliance on the MPIQ as a basis for its assessment, as the MPIQ data consisted solely of local health units' self-

> reported answers and the Ministry did not have any procedures in place for verifying the reliability of the information reported. In this regard, in 2000, the Mandatory Programs Measurement Working Group, comprising representatives from the Public Health Branch and Ontario's Association of Local Public Health Agencies, recommended that the MPIQ be evaluated for its validity as a tool for assessing compliance with the mandatory programs. At the time of our audit, the recommended evaluation had not been conducted.
>
> Based on its review of the completed MPIQs for the year 2000, the Ministry concluded that local health units were 78 per cent compliant with the Guidelines. This was calculated by averaging the overall compliance rate for each of the MPIQ areas across the 37 local health units. However, we noted that this calculation was not a meaningful measure of compliance and was therefore not an indicator of the Actual performance and overall effectiveness of public health programmes across the province. Specifically, we noted the following weaknesses in the compliance calculation and the MPIQ itself.
>
> - The Ministry calculated overall compliance without considering the relative size of individual health units (the population served by the largest local health unit is over 60 times that of the smallest health unit).
>
> - Compliance was assessed in absolute, "either/or" terms, rather than taking into account degrees of compliance. For instance, one health unit was about 10 per cent compliant in a mandatory programme area while another was 70 per cent compliant, yet both were rated equally non-compliant.
>
> - The MPIQ did not elicit compliance data for all of the mandatory programmes and services. For example, the Guidelines include an objective for a coverage rate of 95 per cent for vaccinating children for hepatitis B by the end of grade 7, but the MPIQ did not address hepatitis B vaccination coverage rates.[98]

A compliance monitoring system that does not adequately measure compliance is of little help. Improved monitoring through random assessments was recommended by Mr. Justice O'Connor in the Walkerton Inquiry and also in the 2003 report of the Provincial Auditor;

> Under the Act, the Minister of Health and Long-Term Care may assess whether local health units are providing or ensuring the provision of health programmes and services in accordance with the Guidelines. In addition, Part One of the Walkerton Report, released in January 2002 (the report was the result of the Walkerton Inquiry, established in June 2000 to investigate

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[98] 2003 Annual Report of the Office of the Provincial Auditor of Ontario, pp. 223-4.

> the water-borne E. Coli outbreak in Walkerton, Ontario), recommended that the Ministry conduct random assessments on a regular basis to ensure local health units are complying with the Guidelines. The report also stated that the Ministry should annually track trends in noncompliance in order to assess whether changes are required to the mandatory programmes and whether resources require adjustment to ensure full compliance.[99]

Since SARS the Public Health Division under Dr. Basrur's leadership has made important strides in addressing this problem, sending a clear signal that the Guidelines are to be treated as mandatory standards – not suggestions. The Public Health Division's recently released "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs" advises boards of health and health units:

> To ensure that services provided by health units respond effectively to the needs of Ontarians, the Ministry will actively enforce compliance with the Mandatory Health Programs and Services Guidelines.[100]

Indeed, a heightened level of accountability is a constant theme of the "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs." It advises boards of health and health units:

> In 2005 the Ministry will implement a performance measurement system. This, along with the Program-Based Grant Request and related reporting requirements, will enable the Ministry to strengthen its review of eligible expenditures in order to effectively monitor programme funding and service delivery. These initiatives will build on the public health system's demonstrated interest in working towards increased accountability. The continuing cooperation of all public health providers will be essential to our success in demonstrating accountability and "value for money" as we move forward to revitalize Ontario's public health system.
>
> In addition to improving accountability, the information obtained through the above noted mechanisms will assist us in planning future programme changes and enhancements and will inform the Mandatory Program Review and the Local Public Health Capacity Review committees.[101]

The Guide, for example, provides clear direction on how funds for infection control should be allocated and monitored. It states:

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[99] *Ibid*, p. 223.

[100] Public Health Division, "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs," (Toronto: February 2005), p. 3

[101] *Ibid.*

> The Ministry has clarified the requirements for the Infection Control program (formerly the SARS Short-Term Action Plan) initiated in 2003 …
>
> - For the Infection Control program, health units are required to stay within both the funding levels and the number of full-time equivalent positions identified in the Ministry's allocation letter of December 19, 2003 (supercedes and replaces original allocation letter of September 25, 2003).
> - Funding for this initiative must be used solely for the purpose of hiring and supporting staff that will increase the health unit's ability to monitor and control infectious diseases and enhance its ability to deal with surges of activity related to outbreaks of diseases.
> - Effective with the 3rd Quarter Report due October 30, 2005, health units will be required to submit the "Staffing and Related Costs" report for the Infection Control Program as part of their quarterly reports.
> - Staff funded through this initiative are required to be available to be re-deployed when requested by the Province to assist with large-scale outbreaks in the event that they threaten to overwhelm another local health unit's capacity to respond. This is part of the provincial commitment to improve the capacity of all Ontario public health units to control and respond to infectious diseases.[102]

Meeting the minimum requirements set out in the Guidelines is also an explicit feature of transfer payment agreements between the Province and the local health unit. The recently released Guide states:

> Transfer payments involve an agreement between the Province and the applicable health unit. The Ministry must ensure that prior to advancing any provincial funds to health units, signed agreements are in place that:
>
> - Bind the health unit to achieve specific, measurable results per the Mandatory Health Programs and Services Guidelines;
> - Require health units, as a condition of funding to have in place governance and administrative structures and processes necessary to ensure prudent and effective management of public funds;
> - Require health units to provide periodic reports on financial status and relevant financial and program results achieved;

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[102] *Ibid*, pp. 6-7.

- Clearly establish the province's right to require independent verification of reported information by independent professionals;
- Limit the obligations of the province according to the terms of programs approved by Cabinet; and
- Permit the recovery of provincial funds and/or the discontinuance of ongoing funds in the event of health unit non-performance.[103]

Monitoring and reporting is also an explicit feature of the transfer payment agreements. The Guide states:

> Monitoring and Reporting
>
> The Ministry is required to obtain and review information on the status of health unit eligibility and performance and identify noncompliance with agreements and the failure of health units to demonstrate continued eligibility.[104]

The Guide also outlines the consequences of failing to meet the terms of the funding agreements:

> Corrective Action
>
> The Ministry must initiate corrective action where a health unit has failed to comply with any of the terms of the agreement or where ineligibility is identified. Where appropriate corrective action is outside its direct authority, the Ministry must bring the situation to the attention of officials with the necessary authority.
>
> The nature of corrective action will depend on the type and extent of noncompliance, but in all cases the objective of corrective action is to ensure that provincial funds are used as specified in agreements or returned to the provincial treasury.[105]

Complimenting these initiatives is an innovative change in the role of the Auditor General (formerly called the Provincial Auditor.) The Guide advises boards of health and health unit staff that Bill 18, *An Act Respecting the Provincial Auditor*, which received Royal Assent in

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[103] *Ibid*, pp. 16-17.

[104] *Ibid*, p. 17.

[105] *Ibid*, p. 17.

November 2004, expands the mandate of the Auditor General to conduct discretionary value-for-money[106] audits of local boards of health.

Section 9.1 of the Act states:

> 9.1 (1) On or after April 1, 2005, the Auditor General may conduct a special audit of a grant recipient with respect to a reviewable grant received by the grant recipient directly or indirectly on or after the date on which the Audit Statute Law Amendment Act, 2004 receives Royal Assent.
>
> Exception
>
> (2) Subsection (1) does not apply with respect to a grant recipient that is a municipality.

However, while the Auditor General does not have the mandate to audit municipalities, s. 9.2 of the *Auditor General Act* does provide the following authority with regards to municipal grants:

> 9.2 (1) The Auditor General may examine accounting records relating to a reviewable grant received directly or indirectly by a municipality.
>
> (2) The Auditor General may require a municipality to prepare and submit a financial statement setting the details of its disposition of the reviewable grant.

The Ministry of Health advises that spot audits have been conducted since SARS to determine whether local health units are meeting mandatory infection control guidelines. This sensible initiative needs to become part of the regular accountability and monitoring process authorized and required by law to serve not only as an accountability measure to encourage compliance and identify problems at an early stage, but also as a management tool to identify and correct general trends in noncompliance.

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[106] According to the web site of the Auditor General: "An extremely important part of the Auditor General's mandate is the value-for-money component. Value-for-money audits are assessments of whether or not money was spent with due regard for economy and efficiency and whether appropriate procedures were in place to measure and report on the effectiveness of government programs. Under the Auditor General Act, the Office is required to report to the Legislature significant instances where it is observed that the government is not fulfilling its responsibilities in these areas. To fulfill its value-for-money mandate, the Office annually conducts audits of selected ministry or agency programmes and activities. Major programmes and activities are generally audited every five years or so. Every year, senior management of the Office consider a number of risk factors when selecting which programmes to audit in the coming audit period. These factors include: the results of previous audits, the total revenues or expenditures at risk, the impact of the programme or activity on the public, the inherent risk due to the complexity and diversity of operations, the significance of possible issues that may be identified by an audit, and the costs of performing the audit in relation to the perceived benefits. The results of value-for-money audits are reported on in the Auditor General's Annual Report and constitute a large portion of that document. As well, of all the observations that the Auditor General reports on, value-for-money findings tend to attract the largest proportion of media coverage and interest from the public and from the Standing Committee on Public Accounts."
(See http://www.auditor.on.ca/english/aboutus/whatwedo_frame.htm)

That's why the Commission recommends that the *Health Protection and Promotion Act* be amended to require, by law, the regular monitoring and auditing, including random spot auditing, of local health units to ensure compliance with provincial standards. The public should be able to see any such audits so that they can judge the level of performance of their local health unit.

Effective monitoring, auditing and enforcement require sufficient allocation of resources – to the Provincial Health Division, to the local health units, and to the Auditor General. Too often in the past, the importance of monitoring compliance with public health standards has been given short-shrift – both as a strategic imperative and a funding priority. And yet, as suggested by Mr. Justice Horace Krever in the Commission of Inquiry on the Blood System, by Mr. Justice O'Connor in the Walkerton Inquiry, and by the Provincial Auditor in his 2003 report, monitoring and audits are essential to ensuring that public health standards are maintained so that emergencies are either prevented from developing or can be more effectively contained.[107]

The enactment of a new statutory duty to monitor and audit, together with an increased emphasis on active enforcement, are vital to ensure that problems are found and fixed before they get so big that they require heavy and expensive interventions. With this increased responsibility must come increased resources to fund the monitoring, the audits and the enforcement. As noted below in the section on public health resources, it is idle to enact improvements to the public health system without funding those improvements. Publicly announced initiatives, without adequate funding, mislead the public.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to require by law the regular monitoring and auditing, including random spot auditing, of local health units to ensure compliance with provincial standards. The results of any such audits should be made public so citizens can keep abreast of the level of performance of their local health unit.**

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[107] Mr. Justice Horance Krever, *Final Report, Commission of Inquiry on the Blood System in Canada* (Ottawa: 1997), Volume 3, p. 1054; Mr. Justice Dennis O'Connor, *Part One: Report of the Walkerton Inquiry* (Toronto: January 14, 2002), pp. 263-4; Provincial Auditor of Ontario, *2003 Annual Report* (Toronto; December 2, 2003), pp. 217-44

Composition & Qualification of Boards of Health

Acting on recommendations set out by the Commission in its first interim report[108] and the recommendations in the Walker Report,[109] the provincial government has begun to upload a greater proportion of public health funding. The goal is for the province, by January 2007, to be responsible for 75 per cent of public health funding.[110]

On the principle of say for pay, it follows that the province should assume a greater representation on local boards of health. If the provincial government is paying for three-quarters of the funding, then it should clearly have a greater say than it does now – less than 50 per cent[111] – in its representation on local boards of health.

As for the proportion of municipal and provincial appointees on boards of health, it is anomalous that the province, which now pays over 50 per cent of the overall cost, is restricted by statute to less than 50 per cent of board appointees. It is not just a question of money. Public health is a provincial programme. As noted above, the nature of infectious disease requires stronger central control of the machinery that detects and prevents its spread throughout the province. Should the recommendations in this report be implemented, the degree of provincial control will increase. The governance of a provincial programme, funded mostly by the province, requiring a strong measure of provincial control, should attract a majority of provincial appointees on the local governing boards.

The Commission therefore recommends that the province appoint a majority of the members of each local board of health.

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[108] The Commission in its first interim report recommended the following:

> There is no scientific way to determine the appropriate degree of provincial funding upload for infectious disease surveillance and control. Although a case can be made for 100 per cent funding upload, the persuasive views of a number of local medical officers of health suggest that it would be sensible to upload infectious disease control to a provincial contribution of at least 75 per cent.
>
> It may be that the provincial acceptance of that recommendation, the initiatives taken by Dr. Basrur since her appointment, and the recommendations in this second interim report will fix the underlying governance problems It is the Commission's further position in this report that if these measures do not fix the problems, a clear decision must be made by the end of 2007 whether or not to upload funding and control 100 per cent to the province (p. 175).

[109] The Walker Final Report, p. 74.

[110] Ministry of Health and Long-Term Care Press Release, "New provincial commitment to public health a positive change," May 28, 2004.

[111] Subsection 49(3) of the *Health Protection and Promotion Act* provides that the provincial representation should always be less than half:

> The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health.

A significant practical difficulty attends this recommendation. There has been from time to time a significant delay in the cabinet appointment (by Order in Council) of provincial representatives on local boards, including boards of health. Long standing vacancies interrupt continuity and impair the full functioning of local board. As one medical officer of health noted:

> The other problem with provincial appointees that has been experienced, especially with district health councils, is if the provincial government delays in appointing it can really paralyze governance bodies, so that's another piece that attention needs to be paid to. If you happen to get a government that wasn't supportive of public health, a way to make it very difficult to move forward is to not to fill the empty seats.

The Commission therefore recommends that if cabinet has not by Order in Council filled a board of health vacancy within six weeks, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health.

When asked about increasing the proportion of provincial representation on boards of health, some members of the public health community met this suggestion with caution. They thought that in many cases the quality of provincial appointments did not reflect the degree of commitment to public health required of those in a stewardship role. One medical officer of health observed:

> … from my previous experience, when we had provincial appointees they were not that distinguished or helpful, so I guess it has not been a great experience.

Widespread concern was expressed not only about provincial representatives on health boards, but about the general need for board members to have some qualifications based on experience, interest, and commitment in respect of public health.

Some local medical officers of health have to contend with board of health members whose sole focus is on cutting the budget. As one local medical officer of health described their situation:

> … one of the board member's key agendas is to cut our budget. My budget meeting is next week. [They] have been actively voting against, and trying to undermine what we're doing since the day [they] walked in the door. And it depends on who's at the table, whether or not the more reasonable people at a particular meeting, [are] able to carry the discussion around the table. And frankly, it's very disheartening for me as a medical officer of health and my staff, when they're just trying to do their jobs, to see how the board behaves.

Whether a board of health member is appointed by the province or the municipality, the member has a duty of stewardship not only for the expenditure of public funds but also for the delivery of public health services that adequately protect the public. They should, as members of a board of health, share a public health agenda, interest, and commitment. Unfortunately this is not always the case.

Mr. Scott, the assessor in Muskoka-Parry Sound referred to above, summarized the conflict faced by many municipal officials who also sit on boards of health:

> One central question that needs to be addressed is: Does a conflict of interest exist between a municipal councilor's duty to the taxpayer and his or her duty to the community as a steward of the public health system?
>
> I encountered these issues directly in carrying out the Muskoka-Parry Sound assessment. There was a very serious disconnect between the way the Board interpreted its role and what constituted specific requirements of the HPPA and many of the established principles of good governance.
>
> I believe many of those problems originated from a fundamental misunderstanding of how their duties as Board members differed from their duties as elected municipal representatives. Clearly elected municipal representatives are expected by their electorate to manage the affairs of their jurisdiction in an efficient and effective manner; and of obvious importance, is the need to manage them in accordance with the resources available. This puts pressure on the elected municipal representatives to deliver as much as they can for as little tax demand as possible. It further creates an incentive to pick and choose among priorities to keep taxes down and to focus on priorities that may get the most positive reception from the electorate. An elected municipal representative, when wrestling with difficult municipal budgetary demands, is obviously tempted to consider the heath unit as just another essential service that must play its part in the management of the municipal cost structure.
>
> Unfortunately that is not how it works if the law is to be respected!
>
> I believe that there is a potential conflict most notably arising around what was termed the municipal funding dilemma by Justice Campbell. There is a deep structure problem that drives much of the trouble on boards of health. The municipal funding dilemma is that the municipalities fund public health, a provincial program, from a limited local property tax base. Even though the province underwrites more than 50 per cent of the costs of the program, provincial program growth drives municipal costs. This puts the municipalities in a tough spot, a spot that many municipal councilors feel is unjust and unfair. This is covered succinctly in Justice Campbell's Interim report, *SARS and Public Health in Ontario.*
>
> A municipal councilor who also sits on a board of health has two hats, the municipal politician hat: *keep taxes down* and the public health hat: *fight disease.* When the councilor is sitting on the board of health he or she cannot perform their statutory duty by simply saying *"no increases because I made a*

> *political promise to hold taxes."* The councilor on health board cannot say *"all I care about is the money; no tax increases; public health will have to be cut like everything else."* Those statements would constitute a derogation of his or her duty to the Board of Health. Only one hat can be worn on the Board of Health.
>
> Clearly those who control public funds have a stewardship to ensure value for money. But the councilor on the board of health is bound by legal duty under HPPA which is where his or her first loyalty must lie.
>
> It is not at the option of the Board to avoid their statutory duty to meet the budget requirements of the health unit. The mandatory health programmes and services to be delivered are a statutory requirement. Further, the standards expected for programme delivery are clearly laid out, so there is little room for Board members to adjust the Health Unit budget.
>
> This can make it very awkward for elected municipal representatives who are on the Board as they are open to suggestions from their colleagues that they are not applying the same standards of restraint to the Board that they are applying to other municipal responsibilities. While an unfair shot in the circumstances, it is in fact true, due to the lack of flexibility to suspend or cut back on most programs.
>
> This reality does not at all diminish the importance of the Board or the job of ensuring that the budget is well managed and appropriate for the services delivered, but it does very much limit budgetary discretion.[112]

This is a conflict that is not shared by unelected representatives on the board of health. One local medical officer of health described the important role that the public member of the board of health, an unelected official, played in their board of health:

> We have a citizen who is knowledgeable and interested in public health and they sit on the board. Having them provides for healthy checks and balances between the public members who are much more concerned about public health and the business of public health. They have less of an issue with the hats they wear at the table.

Mr. Scott also noted the value of municipally appointed, non-elected public representatives on a board of health:

> One final thought on municipal representation. Section 49(2) of the HPPA refers to municipal members. The Act defines municipal member as "… a person appointed to the Board of Health by the Council of the Municipality." Consequently, the municipality may appoint members who are not elected members of municipal councils. This could have the

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[112] The Scott Presentation.

> advantage of removing any conflict an elected representative may experience while providing an experienced individual in the community with an interest in public health the opportunity to serve the interests of public health.

The Commission recommends that the *Health Protection and Promotion Act* be amended to require that those appointed to boards of health possess demonstrated experience or interest in the goals of public health – to prevent the spread of disease and to protect the health of the people of Ontario – and that they be broadly representative of the community to be served.[113]

The Commission recommends that consideration be given to a *Health Protection and Promotion Act* amendment to clarify the role and priorities of health board members, the first priority being compliance with the *Health Protection and Promotion Act* and the mandatory public health standards.

One local medical officer of health described their vision for a board whose goal is health protection and promotion supported by links with the new proposed Ontario Health Protection and Promotion Agency:

> I've thought about this, and I thought why do we need a Board. And if you were going to change things, who would you put on your Board? I can imagine there being a Board, and it could be governing, could be advisory, with a senior person from the Boards of Education, so that we could in fact work collaterally with and gain entry to the school boards. We don't have that now. We could have somebody from the business community. Worksites are a venue for public health programmes and services. What a great way of getting a sounding as to whether a service delivery strategy will work, as well as an entrée into the business community. If we did have a successor Board, that's how I would go about structuring it. It would be very strategic, and it would be serving at least two roles. One as a kind of a sounding board type of function, as well as kind of a conduit if you will, into specific sectors that perhaps are not well represented now. So that's how I would do it. It would certainly be far different than it is now, which as you know depends on the whim of the municipal council approval who gets on it, and for many boards of health, it changes yearly. So you make a few gains in terms of their understanding, appreciation and guidance with respect to public health, and just like that, they change. The other thing I would say is, I could imagine a model like CCO, Cancer Care Ontario, if Walker recommends and the government sets up a provincial health protection and promotion agency, that is independent of government, presumably it will be

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[113] Section 2 of the *Health Promotion and Protection Act* provides:

> The purpose of this Act is to provide for the organization and delivery of public health programmes and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario.

> governed by a board of directors, and I could imagine that a local board perhaps could nominate one or two members to the directorship of the Provincial agency, and at a government's level, that could provide the tie-in there, as it does with the Board of Cancer Care Ontario, and regional cancer advisory committees that are set up at the regional level. I could imagine that as well. And that would be another way of ensuring communication between the province and local authorities, in addition to the Chief Medical Officer of Health.

Whatever the ultimate structure and composition of boards it will, as Mr. Scott points out, be in the best interest of members of boards of health to become proactive and ensure they are complying with their obligations under the *Health Protection and Promotion Act* and that their sole focus is the protection of the public:

> It is not only Justice Campbell who is putting the heat on Boards of Health, the Walkerton Report that you are very familiar with, and the new national and provincial emphasis on public health will necessarily place a bigger and bigger spotlight on Health Board affairs. Board members will be locally front and centre for the next SARS-type event; growing health information reporting will put you on the spot if you are not meeting provincial or national performance expectations and statutory requirements.
>
> The simple message is – expectations are changing and changing fast with regard to governance and accountability practices and it will not be good news for Boards of Health that have not fully met expectations if things go awry. Things will go awry! Pandemics happen, and with some of the flu and other infectious disease strains that are developing and society's difficulty in keeping pace with vaccinations and potential cures, the local performance may have a big impact on the spread and/or management of the event. The ability of terrorists to impact public health is real and management and operational incompetence can still have a devastating effect.
>
> When disaster strikes will the Health Board be able to say it met the governance standards expected and did its best when the inevitable questions are asked? That will be the minimum test to protect the community and the Board.
>
> In the event of a public health crisis the Board may not only be under intense public scrutiny but may also be subject to legal action. The issue of whether you met your duties under the law may be subjected to prolonged legal proceedings. This is of little comfort unless you enjoy the spectre of unending legal fees and spending long periods under a potential cloud. A more practical way of assessing whether you are living up to your obligations and hopefully avoid legal proceedings is to apply some simple tests. Given your understanding of your obligations as a board member how would you explain your action as a witness at an inquest or to a Royal Commission or how do you think your position would be portrayed in the media?

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health. In particular, the Ministry of Health and Long-Term Care should:**
    - **appoint a majority of the members of each local board, to reflect the greater proportion of provincial public health funding and influence;**
    - **amend the *Health Protection and Promotion Act* to provide that where cabinet has not by Order in Council, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health;**
    - **amend the *Health Protection and Promotion Act* to require that those appointed to boards of health possess a demonstrated experience or interest in the goals of public health – to prevent the spread of disease and protect the health of the people of Ontario – and that they be broadly representative of the community to be served; and**
    - **consider an amendment to the *Health Protection and Promotion Act* to clarify the roles and priorities of health board members, the first priority being compliance with the *Health Protection and Promotion Act* and the mandatory public health standards.**

Good Governance Best Practices

No matter how the relationship between the province and local public health units takes shape, local oversight of public health should reflect the best practices of good governance.

For many years, the word "governance" had a simple meaning. The Canadian Oxford Dictionary defines it as:

> The act or manner of governing.

In recent years, as demonstrated by its usage in this chapter, "governance" has taken on a wider meaning to include structures, processes and systems to whose goal is,

> … a robust, well-run organization that achieves peak performance and is accountable to the public it serves.[114]

Many studies in recent years have compiled best practices of good public sector governance including the final report of the Broadbent Panel on Accountability and Governance in the Voluntary Sector,[115] the work of American health care consultants Dennis D. Pointer and James E. Orlikoff,[116] and the recently released guidelines issued by the Office of the Premier of the Province of British Columbia.[117]

In Ontario, the best framework for health organizations may be the one developed by Mr. Scott and Ms. Maureen A. Quigley for the Ontario Hospital Association and funded by the Ministry of Health and Long-Term Care.[118] The following key principles for good governance have been derived from the work of Mr. Scott and Ms. Quigley and adapted to the public health environment:

- Boards of local public health units are accountable to the communities they serve: to effectively deliver services; make appropriate use of community resources; and consider their communities' particular needs and requirements.

- Boards of local public health units also are accountable to the province for: utilizing grants in a manner consistent with provincial directions; ensuring compliance with mandatory health guidelines, regulations and legislation; and measuring performance against accepted standards and best practices.

- There must be a clear distinction between the roles of management and the roles of boards. While boards delegate authority to management, they must also monitor, assess and evaluate the actions of management. Management oversees the day to day operations of the health unit within the parameters of mandatory health guidelines, regulations and legislation and in the context of their boards' accountability to the communities they serve and the province.

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[114] Office of the Premier of British Columbia, "Best Practice Guidelines: Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations," (Victoria: February 2005), p. 1.

[115] Panel on Accountability and Governance in the Voluntary Sector, "Building on Strength: Improving Governance and Accountability in Canada's Voluntary Sector," (Ottawa: February 1999)

[116] Orlikoff, James E. and Dennis D. Pointer, "Getting to Great: Principles of Health Care Organization Governance," (San Francisco: 2002).

[117] Office of the Premier of British Columbia, "Best Practice Guidelines: Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations," (Victoria: February 2005)

[118] Quigley, Maureen A. and Scott, Graham W.S., "Hospital Governance and Accountability in Ontario," (Toronto: April 2004)

- In making board appointments, the province and the municipality should select a percentage of members equal to their respective financial contributions. In most cases, this requirement would be satisfied by the above recommendation that the province appoint a majority of board members.

- The province should establish two sets of criteria for board members. One set of criteria should require generic qualities, including the ability to consider issues critically, to work towards a consensus and to foster a positive working environment. The second set of criteria should be more directly applicable to a public health setting, including: a demonstrated interest in public health issues, a scientific or medical background, an understanding of risk communication, or some other qualifications such as business expertise or community development experience.

- Terms of board members should be staggered so that, at any one time, two-thirds of the board is comprised of experienced members.

- A medical officer of health's performance should be measured against agreed objectives.

- A board's performance should be measured against the objectives set by the board and the province.

- The performance of individual board members should be assessed each year in terms of their participation and contribution to the work of the board.

Recommendation

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care introduce a package of governance standards for local boards of health with reference to those sources referred to above, such as the Scott and Quigley governance framework.**

Conclusion

Public health at the local level needs attention. The existing problems faced in some health units cannot be permitted to continue. The government, for the reasons given above, needs to make a clear decision by the end of the year 2007 whether to upload the financing and control of public health 100 per cent to the province and away from the municipalities.

Although there is no consensus on the ultimate solution for the problems of split provincial-municipal governance, there is a consensus that improvements of the kind described above are required even within the existing system

Whatever the ultimate solution, the *Health Protection and Promotion Act* must be strengthened and enforced in the manner described above to ensure a uniform standard of protection across the province. Boards of health must likewise be strengthened to ensure that those who comprise the boards of health are committed to and interested in public health, that they clearly understand their primary focus is to be protection of the public's health, and that they broadly represent the communities they serve.

The current state of affairs cannot continue. The cost of failing to fix will be to risk more disease and death.

Recommendations

The Commission therefore recommends that:

- **The province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review, decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 per cent to the province.**

- **The Ministry of Health and Long-Term Care enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health. In particular, the Ministry of Health and Long-Term Care should:**
    - **Amend and strengthen s. 67 of the *Health Protection and Promotion Act* to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials;**
    - **Take enforcement actions in respect of violations of s. 67;**
    - **Amend the *Health Protection and Promotion Act* to clearly state that the medical officer of health is the chief executive officer of the board of health; and**
    - **Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence**

parallel to that of the Chief Medical Officer of Health, as set out in Chapter 1 of this Report.

- Section 7 of the *Health Protection and Promotion Act* be amended to provide that the Minister, on the advice of the Chief Medical Officer of Health shall publish standards for the provision of mandatory health programmes and services, and every board of health shall comply with the published standards that shall have the force of regulations.

- The *Health Protection and Promotion Act* be amended to require by law the regular monitoring and auditing, including random spot auditing, of local health units to ensure compliance with provincial standards. The results of any such audits should be made public so citizens can keep abreast of the level of performance of their local health unit.

- The *Health Protection and Promotion Act* be amended to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health. In particular, the Ministry of Health and Long-Term Care should:

    - appoint a majority of the members of each local board, to reflect the greater proportion of provincial public health funding and influence;

    - amend the *Health Protection and Promotion Act* to provide that where cabinet has not by Order in Council, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health;

    - amend the *Health Protection and Promotion Act* to require that those appointed to boards of health possess a demonstrated experience or interest in the goals of public health – to prevent the spread of disease and protect the health of the people of Ontario – and that they be broadly representative of the community to be served; and

    - consider an amendment to the *Health Protection and Promotion Act* to clarify the roles and priorities of health board members, the first priority being compliance with the *Health Protection and Promotion Act* and the mandatory public health standards.

- **The Ministry of Health and Long-Term Care introduce a package of governance standards for local boards of health with reference to those sources referred to above, such as the Scott and Quigley governance framework.**

3. HPPA Tuneup

The *Health Protection and Promotion Act* is the legal engine that makes public health go. The work of protecting us from infectious disease, during SARS and in normal times, is conducted under its authority. Actions to protect us against disease – prevention, investigation, and intervention – are all taken under this statute. It is a fundamental tool public health authorities use to protect us against infectious outbreaks.

The *Health Protection and Promotion Act* was proclaimed in force in 1983, replacing the former *Public Health Act*. There have been minor amendments since then, directed mainly at funding arrangements and the machinery of service delivery by local boards of health. These amendments have not altered the confusing structure of the statute.

SARS prompted a few urgent spot amendments.[119] As noted below, the speed with which these amendments were enacted is a tribute to the skill and professionalism of the lawyers in the Attorney General's department, including those seconded to legal branches in other Ministries. These amendments aside, there has been no major overhaul of the statute since 1983. That in itself is no reason to amend it. But the more the Commission worked with the Act in the course of interviewing public health workers, and those in the wider health system who are obliged to comply with it on a daily basis, the more it became apparent that this complex piece of legal machinery needs to be made clearer.

The *Health Protection and Promotion Act* is a convoluted statute, understood by a handful of lawyers and public health officials intimately familiar with it on a daily basis. To those who do not work with it every day the meaning of the *Health Protection and Promotion Act* is not always clear. Even those who do work with it regularly are struck by some of its ambiguities.

In the aftermath of SARS, the powers and authority of public health officials must be carefully reviewed and revised to ensure that during the next infectious disease outbreak, there is no lack of clarity about the precise powers of public health officials to intervene early

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[119] *The SARS Assistance and Recovery Strategy Act*, 2003, S.O. 2003, c. 1. received royal assent (and thereby came into force) on May 5, 2003. Part I contemplates (s.6) various SARS-related leave scenarios, and then provides for various protections including (ss.8ff) reinstatement, protection of wage rates, and protections against reprisals. In essence this portion of the Act establishes a "SARS leave" which is in addition to the entitlement to the emergency leave provided under recent amendments to the *Employment Standards Act, 2000* (*ESA*). The Act also provides protection to employers where a termination was carried out "solely for reasons unrelated to the leave." Part II of the Act provides for a suspension of the retail sales tax on hotel charges during a 5-month period following the SARS crisis. Part III of the Act amends s. 7.1 of the *Emergency Management Act*, which gives the Lieutenant Governor in Council power to make temporary orders to facilitate assistance to victims of an emergency. The new s 7.1(1) specifies that the purpose of the section is to authorize the Lieutenant Governor in Council to make appropriate orders when, in his or her opinion, the victims of an emergency need greater services, benefits or compensation than the law of Ontario provides. Part IV amends Ontario's *Health Protection and Promotion Act* (HPPA) to allow a medical officer of health to issue a s. 22 order to "a class of persons." Section 35 was amended to permit the court to name not only a hospital but some "other appropriate facility" in the order. The amended s.87 provides that the Minister may make an order requiring the occupier of any premises to give up possession for use as a temporary isolation facility for a period of 12 months.

and manage the outbreak effectively. Nor should there be any ambiguity about the precise obligation of members of the community to abide by orders made by public health officials. The legal authority to intervene and act must be unequivocal. Lack of legal clarity produces confusion, wrangling, and delay when time is of the essence.

The Act needs a major overhaul to remove ambiguity and ensure clarity. The Commission, without embarking on such a major review in this interim report, has identified four examples of what needs to be done:

- Simplify disease categories;
- Clarify the three streams of power to intervene, removing the dangerous ambiguity as to the extent of the powers in s. 13 and simplify the process by which the Chief Medical Officer of Health can exercise the powers provided in Part III and Part IV;
- Clarify and simplify the standards of intervention throughout the Act; and
- Strengthen and clarify the powers contained in s. 22 of the Act.

The *Health Protection and Promotion Act* requires amending not only because existing powers are inadequate, as noted above, but because they are unclear, as noted later in this chapter. Some of the Act's problems, such as reporting obligations, quarantine powers, the independence of the Chief Medical Officer of Health and the local medical officers of health, the municipal role, and recommendations for additional powers, are dealt with in other sections of this report. Fixing these will go a long way towards strengthening the Act. For example, amending the reporting provisions as recommended will enhance the ability of the local medical officer of health to learn about infectious cases before they turn into outbreaks. But it is not enough to amend and reword the existing structure. SARS showed us that new infectious diseases can emerge suddenly with enormous consequences for the legal machinery of public health. The lessons learned from SARS and the threat of even deadlier risks, such as avian flu and influenza pandemics, suggest that the *Health Protection and Promotion Act* should be thoroughly reviewed to provide the clearest possible statement of public health authority and its precise limits.

A statute like the *Health Protection and Promotion Act,* which drives the entire public health system and empowers the state to encroach on individual liberty by personal detention and isolation, must above all be entirely clear. This is not the case with the *Health Protection and Promotion Act.* It displays the same problems as those identified in the former Food and Drug Regulations by the Honourable Horace Krever:

> It is recommended that the Food and Drug Regulations be rewritten to make them intelligible … The Food and Drug Regulations, as they are structured at present, are complex, hard to read, and difficult to interpret … It is essential that any regulation be intelligible to the regulated, and it is desirable that it

> also be intelligible to the public. The current regulations fail on both counts ...[120]

Everything said by Justice Krever about the old Food and Drug Regulations applies to the *Health Protection and Promotion Act.* Its complexities and difficulties of interpretation must be removed.

The Commission in this chapter identifies some parts of the *Health Protection and Promotion Act* that require clarification, particularly those parts that deal with infectious disease. This is by no means an exhaustive analysis or proposal for statutory amendment; it merely sets out examples of major revision the Ministry needs to do in consultation with the public health community, and the wider health community. This is a convenient place to observe that a tremendous body of expertise is available in the fairly small group of lawyers who advise local boards of health. They work with the statute on a regular basis and have a firm understanding of what is needed to make the statute clear. Their advice in the process of amendment would be most valuable.

Overview of the Act

The *Health Protection and Promotion Act* presents an assortment of public health powers scattered throughout different parts of the Act. A snapshot of the powers, their triggers and standards of application, show an overall lack of consistency, clarity, and unified organization. To exemplify the need for general reorganization and revision, a handful of specific provisions will be set out below, with brief illustrative comments.

The powers of a local medical officer of health and the Chief Medical Officer of Health are contained primarily[121] in three main parts of the Act: community health protection, communicable disease, and administration. The powers contained in those sections that were relevant during SARS can be summarized in the following chart:

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[120] "The Food and Drug Regulations, as they are structured at present, are complex, hard to read, and difficult to interpret, largely because of the many amendments that have been made over the years. It is essential that any regulation be intelligible to the regulated, and it is desirable that it also be intelligible to the public. The current regulations fail on both counts." (Source: Volume 3, page 1067, of the Final Report of the Commission of Inquiry on the Blood System in Canada, headed by The Honourable Mr. Justice Horace Krever and released in November 1997.)

[121] While these appear to be the main sections which contain powers, other, specific powers can be found in other parts of the Act. For example, the right of entry is included in Part V.

	PART III COMMUNITY HEALTH PROTECTION	PART IV COMMUNICABLE DISEASES	PART VII ADMINISTRATION
APPLICATION	s. 1 – definition of health hazard; condition of premises, substance, thing, plant or animal other than man, or a solid, liquid, gas or combination of any of them, that has or is likely to have an adverse effect on the health of any person (Part I)	Communicable disease as defined in Ont. Reg. 558/91 Reportable disease as defined in Ont. Reg. 559/91 Virulent disease as defined in Ont. Reg. 95/03 and s. 1 in the *HPPA*	s. 86(1) – situation that constitutes or may constitute a risk to the health of any persons
DUTY	s. 10(1) – every MOH shall inspect or cause the inspection of the health unit served by him or her for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit	Set out in mandatory guidelines (representation on hospital IC, consultation with hospital on infection control and outbreak contingency plan, providing advice when needed or requested for communicable disease management)	s. 86(1) – is discretionary on part of Chief Medical Officer of Health (formerly was power of Minister of Health)
POWER	s. 13(1) – MOH or public health inspector may, by written order, require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard	s. 22(1) – MOH by written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease	s. 86 – CMOH may investigate the situation and take such action as he/she considers appropriate to prevent, eliminate or decrease the risk
CRITERIA FOR USING POWER	s. 13(2)(a) – a health hazard exists in the health unit and s. 13(2)(b) – requirements specified in the order are necessary in order to decrease the effect of or eliminate the health hazard	s. 22(2)(a) – communicable disease exists or may exist or there is an immediate risk of an outbreak of a communicable disease in the health unit; and s. 22(2)(b) – the communicable disease presents a risk to the health of persons in the health unit; and s. 22(2)(c) – the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease	s. 86 (1) – situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons
STANDARD FOR USING POWER	s. 13(2) – opinion, upon reasonable and probable grounds	s. 22(2) – opinion, upon reasonable and probable grounds	s. 86(1) – opinion (no reasonable and probable grounds standard)

	PART III COMMUNITY HEALTH PROTECTION	PART IV COMMUNICABLE DISEASES	PART VII ADMINISTRATION
JUDICIAL REVIEW	s. 102(1) – application by CMOH or MOH to Superior Court for an order restraining a contravention of an order s. 102(2) -- application by Minister to Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention of an order	s. 35 – application to Ontario Court of Justice for order of detention, examination or treatment in respect of virulent disease s. 102(1) – application by CMOH or MOH to Superior Court for an order restraining a contravention of an order s. 102(2) – application by Minister to Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention of an order	s. 86.1 (1) – application by Chief Medical Officer of Health to Superior Court of Justice to order a board of health to take such action as considered appropriate to prevent, eliminate or decrease the risk

During SARS, legal issues were for the most part put aside. Patients, health care workers, and institutions complied generally with government direction in the hopes that compliance would stop SARS from spreading.

Simplify Disease Categories

The *Health Protection and Promotion Act* requires amendment to clarify its four overlapping and confusing categories of disease.

The four different categories of disease: infectious, communicable, reportable, and virulent, attract different overlapping sets of legal powers and duties, different reporting duties on the part of doctors and hospitals, and different control powers on the part of medical officers of health and the Minister.

Two categories, communicable, and reportable, are defined in s. 1(1) by way of their inclusion in regulations:

- "communicable disease" means a disease specified as a communicable disease by regulation made by the Minister.
- "reportable disease" means a disease specified as a reportable disease by regulation made by the Minister.

Once the Minister puts a disease into the communicable disease regulation it attracts certain legal consequences, and once the Minister puts a disease into the reportable disease regulation it attracts other legal consequences. The communicable disease regulation specifies 58 diseases and 16 subcategories as communicable.[122] The reportable disease regulation[123] specifies all the communicable diseases as reportable and adds to the list of reportable diseases six other diseases, which are not communicable.[124] Thus all 58 communicable diseases are reportable but six of the reportable diseases are not communicable. The third category, virulent diseases, is defined partly by statute and partly by regulation.

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[122] Ontario Regulation 558/91, Amended to O. Reg. 97/03, Specification of Communicable Diseases made under s. 1 of the *Health Protection and Promotion Act* lists. Acquired Immunodeficiency Syndrome (AIDS);

Subsection 1(1) of the *Health Protection and Promotion Act* defines 12 diseases as virulent.[125] SARS is the only disease specified by regulation as virulent.[126] Most of the virulent diseases are also communicable and reportable except for Ebola and Marburg virus which are neither communicable nor reportable.

A further category of "infectious diseases" is not defined in the statute or regulations. Control of infectious diseases is a mandatory programme that every board of health is required to deliver:

> Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas …
>
> > 2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.

Amebiasis; Anthrax; Botulism; Brucellosis; Campylobacter enteritis; Chancroid; Chickenpox (Varicella); Chlamydia trachomatis infections; Cholera; Cytomegalovirus infection, congenital; Diphtheria; Encephalitis, primary viral; Food poisoning, all causes; Gastroenteritis, institutional outbreaks; Giardiasis; Gonorrhoea; Group A Streptococcal disease, invasive; Haemophilus influenzae b disease, invasive; Hemorrhagic fevers, including: i. Ebola virus disease, ii. Marburg virus disease, iii. Other viral causes; Hepatitis, viral: i. Hepatitis A, ii. Hepatitis B, iii. Hepatitis D (Delta hepatitis), iv. Hepatitis C; Influenza; Lassa Fever; Legionellosis; Leprosy; Listeriosis; Lyme Disease; Malaria; Measles; Meningitis, acute: i. Bacterial, ii. Viral, iii. Other; Meningococcal disease, invasive; Mumps; Ophthalmia neonatorum; Paratyphoid Fever; Pertussis (Whooping Cough); Plague; Pneumococcal disease, invasive; Poliomyelitis, acute; Psittacosis/Ornithosis; Q Fever; Rabies; Respiratory infection outbreaks in institutions; Rubella; Rubella, congenital syndrome; Salmonellosis; Severe Acute Respiratory Syndrome (SARS); Shigellosis; Smallpox; Syphilis; Transmissible Spongiform Encephalopathy, including: i. Creutzfeldt-Jakob Disease, all types, ii. Gerstmann-Straussler-Scheinker Syndrome, iii. Fatal Familial Insomnia, iv. Kuru; Trichinosis; Tuberculosis; Tularemia; Typhoid Fever; Verotoxin-producing E. coli infections; West Nile Virus Illness: i. West Nile Virus Fever, ii. West Nile Virus Neurological Manifestations; Yellow Fever; Yersiniosis.

[123] Ontario Regulation 559/91 *Amended to O. Reg. 96/03***,** Specification of Reportable Diseases.

[124] Cryptosporidiosis, cyclosporiasis, Group B Streptococcal disease, neonatal, Hantavirus pulmonary syndrome, Herpes, neonatal, tetanus. The reportable disease list also includes 4 subcategories of encephalitis that are not listed in the communicable disease regulation.

[125] Cholera, Diphtheria, Ebola virus disease, Gonorrhoea, Hemorrhagic fever, Lassa fever, Leprosy, Marburg virus disease, Plague, Syphilis, Smallpox, Tuberculosis.

[126] Regulation 95/03 made by the Minister on March 25 2003 specifies SARS as a virulent disease. In total there are 13 diseases defined as virulent, in either the Act or Regulation.

A further level of complexity is added by s. 86 (4) which provides that when the Minister of Health exercises the authority of a local medical officer of health under s. 22 in respect of a communicable disease, the reference in s. 22 to a communicable disease shall be deemed to be a reference to an infectious disease:

> For the purpose of the exercise by the Minister under subsection (2) of the powers of a medical officer of health, a reference in section 22 to a communicable disease shall be deemed to be a reference to an infectious disease.

It is difficult to understand why the statute adds this extra layer of undefined "infectious disease" on top of the three defined categories of communicable, reportable, and virulent.

Merely to describe these four categories of disease: infectious, communicable, reportable and virulent, is to illustrate an overlapping and confusing statutory and regulatory framework. Those who work with the *Health Protection and Promotion Act* on a daily basis are so familiar with its nooks and crannies that they do not complain about the dense confusion of disease categories. To members of the public, and even lawyers who are not steeped in its peculiarities, the *Health Protection and Promotion Act* categories of disease look like an impenetrable maze.

There was undoubtedly some original logic in the different categories. It makes sense to have two categories of disease to distinguish between virulent diseases like SARS, which require strong and immediate action, and less dangerous diseases like Herpes, which require less dramatic and immediate intervention. It also makes sense to have some very serious diseases specified by statute so that the Legislative Assembly can control the gate for exercising the extreme powers needed to deal with these dangerous bugs. It also makes sense to give the Minister the urgent power to specify immediately by regulation an emerging disease like SARS when there is no time to await the passage of legislation.

But the present structure of four categories of disease, utilizing different methods of designation, and different legal powers and duties, is unnecessarily complex and confusing.

Recommendation

The Commission therefore recommends that:

- **The four present categories of disease: infectious, communicable, reportable, and virulent, be simplified and reduced to two categories with clear boundaries and clear legal consequences.**

Two Streams of Power

As noted above, the power of the local medical officer of health to act to protect the public is dispersed in two distinct parts of the Act. During SARS, public health authorities derived most of their authority to act from Part IV, Communicable Diseases, but at times had to hope that the Community Health Protection provisions, contained in Part III of the Act, would apply. Yet from the perspective of statutory construction, the fact that the powers in s. 13 are not contained in the communicable disease part of the Act, raises the question of whether they were intended to fill this gap or whether s. 22 was intended to be a one-stop section for powers in relation to communicable diseases.

For example, an unclear application of the Act arises where a hospital's infection control practices are unsafe and, without improvement, may cause a person to be infected with a communicable disease or create a health risk to the public. Under what section of the Act are public health officials authorized to intervene and give orders to the hospital? Some have argued that this power currently exists in the *Health Protection and Promotion Act* and in support of this they point to ss. 11, 13 and 14, which authorize a medical officer of health to inspect and make orders where there is a "health hazard." Action under these sections, however, is premised on there being a "health hazard."

Health hazard is defined in s.1 of the Act as follows:

> "health hazard" means,
> (a) a condition of a premises,
> (b) a substance, thing, plant or animal other than man, or
> (c) a solid, liquid, gas or combination of any of them,
> that has or that is likely to have an adverse effect on the health of any person.

First of all, it is worth noting that the powers set out in ss. 11 through 14 are contained in the community health section of the *Health Protection and Promotion Act.* This part of the Act focuses clearly on environmental and occupational health hazards, not on infectious disease risks which are addressed separately in Part IV, Communicable Diseases. That noted, it is doubtful that these powers were intended to address any situations that arose during SARS, let alone the specific problem of infection control and infectious outbreaks in hospitals. Moreover, the standard of proof in s. 13 makes it inappropriate for use in the context of infectious diseases in hospitals, and even more importantly it stretches the structure, definitions, and context of Part III to apply these powers to hospital infection control and oubreak problems. It reflects a high degree of legal ambiguity in the *Health Protection and Promotion Act* when public health lawyers can hold sharply divided views on this fundamental issue.

If the powers set out in s. 13 are intended to apply to communicable diseases, the *Health Protection and Promotion Act* should be amended to clarify this point.

Recently, the issue has arisen as to whether the power in s. 13 would allow decontamination of a person. In September, 2004, the Ministry of Health and Long-Term Care, expressed the opinion to Mr. Katch Koch, the Clerk of the Standing Committee on Justice Policy, that s. 13 of the *Health Protection and Promotion Act* could authorize decontamination of a person:

> If a situation exists where a possible toxic substance may have contaminated persons in the community (for example the "white powder" scare that occurred across North America following the events of September 11, 2001)

it may be appropriate to consider the exercise of certain other powers under the Health Protection and Promotion Act.

Under section 13 of the Act, a medical officer of health or a public health inspector by a written order may require a person to take or refrain from taking any action that is specified in the order in respect of a health hazard. An order may be made under section 13 where the medical officer of health or the public health inspector is of the opinion, on reasonable and probable grounds:

(a) that a health hazard exists in the health unit served by him or her; and

(b) that requirements specified in the order are necessary in order to decrease the effect of or eliminate the health hazard.

An order under s. 13 may include, but is not limited to:

(a) requiring the vacating of premises;

(c) requiring the placarding of premises to give notice to an order requiring the closing of the premises;

(e) requiring the removal of anything that the order states is a health hazard from the premises or the environs of the premises specified in the order;

(f) requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order; and

(i) prohibiting or regulating the use of any premises or thing.

Because the list[127] is not exhaustive, it is arguable that a term could include ordering decontamination of a person, where the legal test under s. 13(2) is met.

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[127] This is not a complete list of the specified powers in s. 13(4). Subsection 13(4) provides:

An order under this section may include, but is not limited to,

(a) requiring the vacating of premises;

(b) requiring the owner or occupier of premises to close the premises or a specific part of the premises;

(c) requiring the placarding of premises to give notice of an order requiring the closing of the premises;

(d) requiring the doing of work specified in the order in, on or about premises specified in the order;

(e) requiring the removal of anything that the order states is a health hazard from the premises or the environs of the premises specified in the order;

(f) requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order, It is far from clear, and arguably doubtful, that this interpretation of the Act is correct. While s. 13(1) states that the medical officer of health may require a person to take or refrain from taking any action that is specified in the order in respect of a health hazard, a review of the types of things authorized reveals that none of the contemplated actions include a power to do something to a person physically, such as detention, examination and treatment, as is authorized in s. 22 of Part IV. On the contrary, all powers specified in s. 13 relate to directions to do something or refrain from doing something to a premises. While one might argue that the powers in s. 13(4) are not exhaustive, the fact that the statute does not specifically prohibit something does not mean that it is permitted. Part III, read as a whole, does not suggest that any of the powers are intended to authorize any physical action taken against a person.

As noted later in the chapter titled "*A Stronger Health Protection and Promotion Act,*" the decontamination of a person gives rise to a number of issues including their right to refuse, and the process by which a person may be decontaminated against their will. Unlike the powers in s. 35, contained in Part IV, there is nothing in Part III that establishes a process by which a person who refuses to abide by an order of the medical officer of health may be legally forced to do so. It would appear that s. 102(1),[128] which allows a Superior Court judge to restrain a contravention of an order made under the Act, would be the avenue of enforcement. Contrasting the powers in s. 35 with those contained in s. 102(1) suggests that it is very unlikely that s. 102(1) was intended to force someone to comply with a process or procedure ordered against them physically. There is no authority in s. 102(1) to force a person to submit to such a procedure or process; rather it speaks to restraining a contravention. Furthermore, there is no authority to detain a person in s. 13. There is a very strong argument that nothing in s. 13 authorizes the medical officer of health to make an order that involves interference with or direction over a person's bodily integrity.

> (g) requiring the destruction of the matter or thing specified in the order;
>
> (h) prohibiting or regulating the manufacturing, processing, preparation, storage, handling, display, transportation, sale, offering for sale or distribution of any food or thing;
>
> (i) prohibiting or regulating the use of any premises or thing.

[128] Subsection 102(1) provides:

> Despite any other remedy or any penalty, the contravention by any person of an order made under this Act may be restrained by order of a judge of the Superior Court of Justice upon application without notice by the person who made the order or by the Chief Medical Officer of Health or the Minister.
>
> Proceedings to prohibit continuation or repetition of contravention
>
> (2) Where any provision of this Act or the regulations is contravened, despite any other remedy or any penalty imposed, the Minister may apply to a judge of the Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention by the person committing the contravention, and the judge may make the order and it may be enforced in the same manner as any other order or judgment of the Superior Court of Justice.

There is a stream of legal opinion, exemplified by the Ministry of Health and Long-Term Care opinion set out above, that s. 13 can be used to supply any deficiency in other parts of the Act, such as Part IV, Communicable Diseases. Unfortunately, where the authority to act is unclear or not explicitly authorized, this is a section to which public health lawyers must resort, in hopes that the interpretation will stand. It is unacceptable to have important powers, such as the power to issue directives to health care facilities in respect of unsafe infection control practices, or the power to decontaminate individuals, subject to uncertainty and legal wrangling and debate. When these powers are needed it will hamper public health's ability to respond if debate and legal wrangling ensue and lawyers spend days writing legal opinions trying to prove whether the power exists. The Act must be clear. If the current system of three streams of operational powers contained in Part III, Part IV and Part VII is to be maintained, it must be apparent to anyone using the *Health Protection and Promotion Act* what each Part authorizes and how one Part relates to another.

Finally, in respect of s. 13 of the Act, some individuals and organizations have submitted to the Commission that the definition of "health hazard" needs to be reconsidered and expanded.[129] The precise language needed to define a health hazard is beyond the expertise of the Commission. It is recommended, however, that the Ministry of Health, in consultation with local public health officials, review the current definition with a view to determining if there are situations amounting to health hazards that are not currently captured in the Act.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to clarify whether the powers contained in the various parts of the Act apply outside of the Part of the Act in which the power is contained. For example, does s. 13 apply in the case of a communicable disease?**

- **The Ministry of Health and Long-Term Care consider whether the definition of "health hazard" needs to be updated or expanded.**

Clarify Standards for Intervention

Another aspect of the Act requiring clarification is the apparently haphazard overlapping standards for intervention. The standards for intervention are the legal triggers that allow the medical officer of health to act. They are, however, scattered throughout the Act in a seemingly haphazard and illogical manner:

- for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit (s. 10(1));

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[129] For example a number of submissions recommended that "health hazard" be amended to include a person.

- necessary in order to decrease the effect of or to eliminate the health hazard (s. 13(2));
- immediate risk of an outbreak of communicable disease (s. 22(2)(a));
- communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health (s. 22(2)(b));
- necessary in order to decrease or eliminate the risk to health presented by the communicable disease (s. 22(2)(c));
- significantly increase the risk to the health of any person (s. 22(5.0.3));
- significant risk to the health of the public (s. 35(11)(b));
- a risk to the health of any persons (s. 86(1));
- likely to have an adverse effect on the health of any person (s. 96(4)(c)(d) and (e)).

The Act has both hard triggers, such as reasonable and probable grounds, and soft triggers, such as simply having the opinion that a risk to the public's health exists. While these differential triggers may be appropriate, there does not seem to be any logic to their current placement in the Act.

For example, in s. 22 of the Act, the standard of intervention is "opinion, upon reasonable and probable grounds." This is a high hurdle to meet. In the case of communicable diseases, it is a hard trigger that demands that the medical officer of health, before making an order, meet the criminal or quasi-criminal standard of proof required before instituting *Criminal Code* or *Provincial Offences Act* proceedings.[130] This high criminal standard of proof may not exist in the early stages of an infectious disease outbreak or infection control problem. What then is the authority to act where a health risk or hazard is present but does not meet the trigger for intervention in s. 22, either because it is in the early stages and unknown or because it is something that is not a classified communicable disease?[131]

Again, this standard of intervention may be appropriate for some actions but too high for others. For example, when deciding to close a hospital, one would expect the medical officer of health to be governed by a high standard of intervention; one would expect that this would be a "hard" trigger. On the other hand, an order under s. 22(4)(d), requiring that a place be cleaned or disinfected, need not require a high standard of invention and therefore should be a "soft" trigger.

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[130] R.S.C. 1985, C-46, s. 504; R.S.O. 1990, c. P-33.

[131] The same standard applies in s. 13 and the same issue arising through the use of this standard in Part IV, arise in its use in Part III.

It is time to take a hard look at this disparate collection of standards, and to develop some consistency, some scalable set of triggers so there is a clear progression from a low-end risk with low-end interventions to high-end risk with high-end interventions. What is needed is a hard look at the standards and legal triggers for intervention, and an adjustment to ensure that the soft trigger is available where the danger of inaction outweighs the need for objectively provable grounds, but that the hard trigger is maintained for other cases.

Recommendations

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care review the numerous standards of intervention contained in the Act, examples of which are noted above, with a view to amending the Act to simplify and rationalize the apparently haphazard and overlapping standards for intervention, and to ensure that whether there is a hard trigger or a soft trigger, it should be rationally connected to the power being wielded.**

- **Section 22 of the *Health Protection and Promotion Act* be amended to adjust the standard of intervention to provide that the medical officer of health can take necessary action without the criminal or quasi-criminal standard of objective proof on reasonable and probable grounds.**

Strengthen Section 22

In respect of communicable diseases, public health officials derive most of their power from s. 22. They rely on it to give them authority to intervene and take action to protect the public. Because of its importance, Ministry officials must be vigilant in ensuring that the section works and that any weakeness or legal ambiguities are addressed clearly and swiftly.

For example, some public health officials have expressed concern about the practical dificulties of administering s. 22 of the Act particularly where the subject of the order is something other than an actual person, for instance a homeless shelter. Subsection 22(1) provides that an order may be made against a "person". Subsection 22(5) provides that an order may be directed to a person:

a) who resides or is present;

b) who owns or is the occupier of any premises;

c) who owns or is in charge of any thing;

d) who is engaged in or administers an enterprise or activity;

in the health unit served by the medical officer of health.

It may be difficult to determine legal ownership or administration in a timely fashion. If the order is directed at an institution and it requires steps that affect many people, it is critical to direct the order to a wider audience than the person who occupies the premises. Ascertaining who is "in charge" may also be difficult and time-consuming. The problem requires examination by the Ministry of Health and Long-Term Care in consultation with the public health legal community.

Another issue raised by those working in the field is the lack of clarity whether a s. 22 order written and served in one health unit applies outside of that health unit. Those with infectious diseases do not always stay in one unit. When they cross boundaries, the unit in which they are found should be entitled to rely on the existing order from the other unit. It is a waste of scarce resources if every unit must produce their own written order each time an infectious person decides to cross health unit boundaries.

Recommendations

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care, in consultation with the public health community, examine the issue of any practical difficulties of administering s. 22, with a view to make it more effective for those who rely on its powers.**
- **The *Health Protection and Promotion Act* be amended to provide that an order made under s. 22, in respect of a person infected with a communicable disease, is valid in any health unit in Ontario.**

Conclusion

The above highlights just a few examples of confusion in the Act. The Act must be clear and workable for those who use it to obtain their day to day authority to protect the public's health. Otherwise, uncertainty and confusion will be the refuge for a noncompliant person or institution. Action that is necessary to protect the public may be delayed as public health officials and lawyers try to determine what they can do and when. If they are bold enough to act in the face of uncertainty, they risk legal challenges to their authority, which may in turn delay their ability to act effectively.

The *Health Protection and Promotion Act* is a complex statute that has served the people of Ontario well since its inception. That being said, in the aftermath of SARS, it is time for the Ministry of Health and Long-Term Care to review the Act, in consultation with the Attorney General and those who work daily with the Act on the front lines of public health defence.

Recommendations

The Commission therefore recommends that:

- **The four present categories of disease: infectious, communicable, reportable, and virulent, be simplified and reduced to two categories with clear boundaries and clear legal consequences.**

- **The *Health Protection and Promotion Act* be amended to clarify whether the powers contained in the various parts of the Act apply outside of the Part of the Act in which the power is contained. For example, does s. 13 apply in the case of a communicable disease?**

- **The Ministry of Health and Long-Term Care consider whether the definition of "health hazard" needs to be updated or expanded.**

- **The Ministry of Health and Long-Term Care review the numerous standards of intervention contained in the Act, examples of which are noted above, with a view to amending the Act to simplify and rationalize the apparently haphazard and overlapping standards for intervention, and to ensure that whether there is a hard trigger or a soft trigger, it should be rationally connected to the power being wielded.**

- **Section 22 of the *Health Protection and Promotion Act* be amended to adjust the standard of intervention to provide that the medical officer of health can take necessary action without the criminal or quasi-criminal standard of objective proof on reasonable and probable grounds.**

- **The Ministry of Health and Long-Term Care, in consultation with the public health community, examine the issue of any practical difficulties of administering s. 22, with a view to make it more effective for those who rely on its powers.**

- **The *Health Protection and Promotion Act* be amended to provide that an order made under s. 22, in respect of a person infected with a communicable disease, is valid in any health unit in Ontario.**

4. Stronger Health Protection Powers

The *Health Protection and Promotion Act*, which provides the legal machinery for our defence against infectious disease, needs to be stronger. Public health officials must be able to act quickly and decisively in the face of a public health risk. Quick action can stop an outbreak before it starts. Although emergency powers may be available after an outbreak gets out of control, it is the daily powers in the *Health Protection and Promotion Act*, powers of investigation, mitigation, and risk management, that prevent public health emergencies from developing. These daily powers require strengthening.

SARS demonstrated the importance of three key aspects of infectious disease prevention and management by public health officials: first, access to information about cases and situations in health care institutions and in the community that may pose risks to public health; second, the authority, resources and expertise to investigate such cases and situations to determine any risk to the public's health; and third, the authority, resources and expertise to intervene and take appropriate action necessary to protect the public's health. These three key functions have to be supported by adequate resources and legal powers.

The Commission has identified seven fields of public health activity that require additional authority under the *Health Protection and Promotion Act*:

- Authority of public health in relation to infectious diseases in hospitals;
- Authority of public health officials to acquire information necessary for them to protect the public from a health risk;
- Authority of public health officials to investigate health risks to the public;
- Authority and process by which the Chief Medical Officer of Health can establish an adjudication system to review, where appropriate, decisions of local medical officers of health in respect of case classification;
- Authority of the Chief Medical Officer of Health to issue directives to hospitals and other health care institutions;
- Authority as a last resort to detain noncompliant individuals who pose a health risk to the public, subject to an immediate court hearing; and
- Authority as a last resort to enter a private dwelling to execute an order made under the Act or in exigent circumstances to enter without a warrant, followed by a court hearing.

Health protection legislation requires a scaled response, with powers that increase as the risk increases. It is not good enough to act after a public health problem has erupted into the community. The authority is required to manage risk proactively to prevent a potential public health problem from becoming a public health emergency.

Dr. Basrur, in her submission to the Justice Policy Committee considering the issue of emergency legislation, referred to the need to strengthen the power for medical officers of health to deal with day to day risks to public health. She emphasized the need for public health's response to be ramped up depending on the level of risk, without having to declare a provincial emergency so as to have the legal authority to utilize those powers. She stated:

> You might, in the case of the health legislation, have a series of what I call "scalable" powers that are consistent with the day-to-day structure of the regulation of public health, not totally divorced from it, so that when you start with what seems like one case, two cases, four cases, and, "Gee, it's not just one institution, it's two institutions, and yes, there were workers who crossed over and we're not sure where a third one may have worked because we can't find that person," you want to be able to scale up but not have to invoke a new statute entirely in a non-provincial-emergency situation. You want to be able to scale up, scale back, scale up in particular geographic areas or on particular functional areas so that you've got a sensible response.
>
> Now, it is possible to have that kind of provision built into individual statutes – the Health Protection and Promotion Act, the Nursing Homes Act, the Homes for Special Care Act, the Charitable Institutions Act, all of the rest of them. You might have it in the Ministry of Health and Long-Term Care Act. Not being a lawyer, I'm not going to try to nuance what the differences would be. All I will say is that from a public health standpoint, I need the latitude, and I know the local medical officers of health need the latitude, to say: "These are our authorities. We know what we can do on a daily basis. We know if we have an urgent situation we can ramp up this quickly, but when we hit certain parameters, we've got to escalate it to the province, because this really goes beyond our borders; it goes beyond our competence," or, "It's multi-jurisdictional, and therefore a comprehensive response needs provincial coordination and control."[132]

The idea is to have a range of powers available daily to deal with any public health problem short of a provincial emergency. Once the problem rises to a level where emergency machinery and powers and the full resources of government are required, a bright line would be crossed and a provincial emergency would be declared. Once a provincial emergency is declared, the emergency powers kick in and there would be no more question of scalable powers. But the existence of a strong emergency management legislation does not negate the fact that public health officials must have their powers strengthened to allow them to deal with a public health problem short of it becoming an emergency.

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[132] Justice Policy Committee, Public Hearings, August 18, 2004, p. 141.

To achieve this goal the *Health Protection and Promotion Act* must be strengthened. Medical officers of health must be involved in and aware of infection control issues as soon they arise in health care facilities. The powers and obligations set out in the *Health Protection and Promotion Act* must enable public health officials to become aware of unusual clusters of illness and reportable events both in health care facilities and in the community, they must empower them to direct epidemiological investigations where necessary, and they must authorize them to intervene and act, by making orders to individuals, groups, institutions and health care facilities for the protection of the public. Not all infectious disease outbreaks will require the declaration of a provincial emergency or resort to the broader emergency legislation. If the daily authority in the *Health Protection and Promotion Act* is strong enough, emergencies will be more preventable and the use of emergency powers will very seldom be necessary.

The Relationship Between Public Health and Hospitals

Faced with the risk of infectious disease outbreak, public health and hospitals need to work quickly and need to work together. There is no time for turf wars, procedural wrangling, jurisdictional disputes, or fine legal arguments. Deadly viruses do not stand still while hospitals and public health officials sort out their differences.

As noted in the Commission's first interim report, the sudden onslaught of SARS forced public health and hospitals to work together in a way and scale never previously encountered or even contemplated. This was no problem in some parts of the province because the local health unit and the local hospitals had good working relationships, including an active public health presence on hospital infection control committees. For other parts of the province, however, the opposite was true. It proved difficult in some cases for public health and hospitals to work together in a new and unfamiliar relationship driven by a crisis for which no one had planned. This uneasy and unplanned relationship detracted in some cases from the mutual fight against SARS.

A critical issue during SARS and now is the management of infection control concerns or outbreaks or potential outbreaks of infectious diseases in health care institutions and the role of public health. There are two distinct issues: first the role of public health when there is an infection control problem that poses a risk to the community, and second the role of public health in infection control programmes and standards in general. More will be said about the latter issue in the final report together with the story of what happened during SARS.

This report will focus in a preliminary way on the structures and relationships required between public health and hospitals to prevent, detect, investigate and manage infectious outbreaks in hospitals.

The Commission received many submissions on the relationship between public health and hospitals in respect of the prevention and management of infectious diseases within health care facilities. One common theme throughout the submissions, received from both the public health and health care communities, is the need for greater clarity in their respective roles and relationships in respect of infection control. Both sides want clarity. Both want to work together more effectively. Both sides realize that the working relationship, whatever it may become, must above all be transparent with clear role definitions and clear lines of authority and accountability.

As noted in the Commission's first interim report, public health authorities, at least in theory, have some role in hospital infection control. The Mandatory Guidelines under the *Health Protection and Promotion Act* provides as follows:

> The Board of Health shall ensure appropriate input to hospital infection control programs in the health unit. This shall include as a minimum:
>
> a. representation of the Medical Officer of Health or designate on each hospital infection control committee;
>
> b. reporting of designated communicable diseases from hospitals, including emergency rooms and out-patient clinics, to the Medical Officer of Health as required under the provisions of the *Health Protection and Promotion Act*;
>
> c. consultation with the hospital infection control committee on the development and revision of infection control policies and procedures and an outbreak contingency plan;
>
> d. providing advice when requested or when needed for the appropriate management of communicable diseases and infection control;
>
> e. providing epidemiological information as needed regarding communicable diseases existing within the community and other institutions; and
>
> f. collaboration or assistance in annual in-service education for hospital staff about communicable diseases.

The Guidelines provide for communication, advice and consultation between public health and hospitals in respect of infection control. But they give public health no authority and they require from hospitals no accountability. These Guidelines have not always been followed. Nor have they typically been enforced. Some hospitals had a minimal, if any, relationship with public health authorities around infection control. In those cases where some relationship existed, the relationship was sometimes poorly defined and poorly understood. As noted in the Commission's first interim report there is great confusion and uncertainty around the respective roles, responsibilities, authority and accountability of public health and hospitals in infection control and infectious outbreaks in hospitals.

The present uncertainty makes it obvious that legislation is required to clarify these roles and responsibilities. But the most exquisite legislation will not solve the problem without an underlying framework of cooperation and an underlying attitude of respect between hospitals and public health authorities. While there will always be room for disagreement, it is essential to foster an atmosphere of mutual respect around the respective authority and accountability of hospitals and public health in respect of infection control. Some think this will be achieved if hospitals have clear primary responsibility for managing outbreaks within an institution, subject to a greater role for public health in surveillance, investigation and, as a last resort, intervention.

As one submission to the Commission suggested:

> Authority for managing outbreaks of infection should be vested within the infection control officer of the hospital with the requirement that all outbreaks are reported immediately to the medical officer of health. The medical officer of health and the infection control officer of the hospital must work collaboratively to control infections in their respective jurisdictions and keep each other informed of infectious disease outbreaks.

While the goal of any professional relationship should be collaboration and cooperation, clear lines of authority are also required. The public interest requires that a health care facility's management of infection control problems, infectious disease outbreaks, or other public health risks be subject to investigation and, if necessary, intervention, by public health authorities. The medical officer of health and the Chief Medical Officer of Health require the authority and the resources to intervene whenever there is a risk to the public health, no matter where that risk is situated. The fact that a hospital may have an infection control programme does not negate the need for public health officials to intervene when an infection control problem or an outbreak present public risk. The ease with which a hospital based infection can spread to the community makes it essential that public health officials have the power to investigate, and if necessary, to require a hospital to take positive steps to prevent the spread of infection within the hospital and from the hospital to the community. As one submission received by the Commission observed:

> The *Health Protection and Promotion Act* should include more appropriate accountability mechanisms to ensure public health exercises control over all health care facilities, including hospitals, to ensure better oversight of infection control procedures.

Public health officials and experts can monitor a potential problem and act on it in time only if they know about it. Unless they are informed in its early stages, later investigation and intervention may come too late. It is too late to involve public health officials after a case is absolutely confirmed or an outbreak has clearly developed. The specific powers to enable public health officials to intervene and act to protect the public's health from infectious diseases are discussed below.

As a starting point it must be clear in the *Health Protection and Promotion Act* that public health has a role to play in infection control, whether in a hospital, a long-term care facility or a private clinic. The medical officer of health must have a legal duty, entrenched in the Act, to monitor, investigate and intervene where necessary in cases of infectious diseases, or where inadequate infection control standards or procedures pose a threat to public health. A curious gap in the Act is a positive duty to inspect and monitor community health hazards under s. 10 and environmental and occupational health hazards under s. 12, yet no concurrent duty to do the same in the case of communicable diseases. Part of the resistance to public health intervention may be addressed if it were made clear that this is their job and that they are legally required to be involved. The entrenching of these duties as a statutory requirement would also make it more difficult for municipalities to cut spending in the area of infectious disease prevention and management. Supported by the statutory duty, the local medical officers of health could point out that they are legally required to perform these functions.

The first step to strengthening the relationship between public health and hospitals is to reinforce the requirement that public health have a presence in the infection control committees of all hospitals in the province. To this end, the Commission recommends amending the *Health Protection and Promotion Act* to provide that each hospital infection control committee must have as a member the medical officer of health or his or her designate. While this simply puts into the Act what already exists in the Guidelines, it gives it the force of law, with a view to ensuring that it is a duty that cannot be overlooked or under-resourced.

It is further recommended that the Act be amended to impose a positive duty on public health officials to monitor, investigate, provide advice and intervene where necessary in the case of communicable diseases. The present language of the Mandatory Guidelines, which implies that the role of public health is optional, as if they are guests to be heard in hospitals only when invited, is unacceptable. Public health has a role in institutional infection control whenever there is a potential danger to the public's health.

Recommendations

The Commission therefore recommends that:

- **The role and authority of public health officials in relation to hospitals be clearly defined in the *Health Protection and Promotion Act* in accordance with the following principles:**
    - **The requirement that each public health unit have a presence in hospital infection control committees should be entrenched in the Act; and**
    - **The authority of the local medical officers of health and the Chief Medical Officer of Health in relation to institutional infectious disease surveillance and control should be enacted to include, without being limited to, the power to monitor, advise, investigate, require investigation by the hospital or an independent investigator, and intervene where necessary.**

Information

As noted earlier in this report, the ability of public health officials to intervene in the case of a health risk is dependent on them being informed. This can only be done where public health officials have access to current information about the existence or suspected existence of an infectious disease within a hospital or any other health care institution or facility. As one public health lawyer commented:

> We're really, quite frankly, waiting for the hospitals and practitioners to do the right thing and contact the local health unit if there's something that's getting out of hand. I think experience in the last two years has shown that that's not always satisfactory. If you give the medical officer of health a power to require compliance when an institution is engaging or stepping up its infection control procedures, then I think that you get over the hurdle of the hospital's lawyers saying, wait a second, you don't have any obligation to report this, let's just keep this in-house.

The reporting of infectious diseases information is dealt with in the following chapter of this report. It is critical that public health be informed of cases in hospitals and other health care settings immediately, so it can take steps to protect the public. Amending the specific sections of the Act to clarify and expand existing reporting obligations is only one part of the solution, however. Many public health professionals have suggested that it is not enough to simply be advised when there is a confirmed case of a reportable or communicable disease in a health care institution. By the time that determination is made the disease may have already spread to numerous people.

The *Health Protection and Promotion Act* does not deal with public health risks that fall outside the limited definitions within the statute. The local medical officer of health has the power to act in the face of a "health hazard" as defined in the Act[133] or in relation to diseases that are defined as "communicable" under the Act. But public health risks may well arise that do not meet the limited definitions of "health hazard" but are not identified as a "communicable disease" under the Act.

There are two parts to this problem: first the ability of doctors and other health care professionals to inform public health voluntarily of any public health risk; second the ability of public health officials to compel the disclosure of information that does not fall within the categories requiring reporting under the *Health Protection and Promotion Act*. The latter problem, enabling public health officials to compel the disclosure of information outside of that clearly set out in the Act, will be dealt with in the following chapter on reporting.

The solution does not lie in amending the regulations each time a new illness or health hazard presents itself. Consider the example of SARS. Had a hospital in Ontario been confronted with one or more SARS cases before the mysterious new disease was identified, given a name, and classified as communicable, and taken the position that they would deal with the matter internally and not alert public health officials, there would have been no legal requirement for them to report details about the case or cases prior to March 25, 2003.[134]

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[133] "Health hazard" means, (a) a condition of a premises, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of them. See s. 1(1) of the *Health Protection and Promotion Act*.

It is essential that public health be aware of and be able to monitor, investigate and where necessary direct that action be taken in relation to health risks that do not meet the limited categories currently set out in the *Health Protection and Promotion Act.* Physicians who diagnose and treat patients must be able to report to public health a case of illness or an infection control issue, which may, if not addressed, represent a public risk. The principle is clear. The difficulty is to define the trigger for such an unspecified situation.

A possible model for reporting public health risks generally can be found in Quebec's *Public Health Act.*[135] Under this Act, physicians and institutions have positive obligations to report certain specified diseases (as designated by the Minister) but also must report to the public health director,[136] situations where the health of the population is threatened. Section 93 of the Act provides:

> 93. Any physician who suspects the presence of a threat to the health of the population must notify the appropriate public health director.
>
> Possible Threat
>
> Health and social services institutions must report to the appropriate public health director any situation where they believe on reasonable grounds that there exists a threat to the health of the persons who are present in their facilities.[137]

Under the Quebce Act, "health threat" is defined in s. 2, as follows:

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[134] On March 25, 2003, amendments to Ont. Reg. 559/91 and Ont. Reg. 558/91 were filed as well as Ont. Reg. 95/103. The filing of these regulations designated SARS as a communicable, reportable and virulent disease. The regulations came into effect on March 25, 2003, the date they were filed but for purposes of enforcement did not come into effect until April 12, 2003, the date the regulations were printed in the *Ontario Gazette* unless actual notice of the regulation was given. For example, Toronto Public Health attached a copy of the regulations to orders served before April 12, 2003 to ensure notice was given. See ss. 3 and 5(3) of the *Regulations Act*, R.S.O. 1990, c. R-21.

[135] R.S.Q. S-2.2.

[136] Under s. 371 of the *Health and Social Services Act*, each region must appoint a public health director. The position of "public health director" is similar to the position of medical officer of health under the Ontario regime.

[137] It is important to note that these reporting obligations have certain limitations. They do not include a requirement to report sexually transmitted diseases or to disclose personal or confidential health information unless the public health authority requires such information to exercise their powers under part XI of the Act, which sets out the powers public health may exercise in the event of a threat to the health of a population.

> A threat to the health of the population means the presence within the population of a biological, chemical or physical agent that may cause an epidemic if it is not controlled.

As attractive as this broad and expansive language is, it imposes a reporting duty which is vague and unspecified. As one public health official noted, it is one thing to allow a physician the discretion to report in such an unspecific event, but it is another to hold them potentially professionally liable or punishable under the Act for failure to report in that same situation:

> … it makes sense that a physician has the capacity to do it without reprimand but if they don't are they sued or liable, that would be very discouraging though … if the physician, he or she feels that there is some concern, they could do so and not then be protected from reprimand on that, but at the same time, well were you not aware of something and how come you did not so therefore you are charged. It is very difficult. Right now we are working on seeking a voluntary mechanism to ask them to report proactively rather than saying well I better check with the CMPA [Canadian Medical Protective Association] and every legal obligation and cover all my P's and Q's before I report, it would be too late.

Another suggestion is to amend the Act to require the reporting of an unusual cluster of unexplained illness, or to establish some threshold criteria to capture an unusual and potentially dangerous event that has not yet been determined to be a reportable disease. As one public health lawyer told the Commission:

> … to change the wording of the regulation to broaden it, say that more things get reported to public health units and that when public health asks for it, then the hospitals are required to provide it. And that, I think, covers up some of the gaps. But it doesn't get at this initial problem that public health units are all, I think, saying when something, whatever that something is, is going on, we want you to report it. I think going to try and come up with some of those triggers, like sitting down with public health and saying, okay guys, sit down, what are the words that we can use, and we just didn't have time to do that. But they've got the triggers in s. 38 for the reportable events for the immunization. They've got triggers there for that kind of situation. I think we should come up with our own triggers, like the immunization situation, where it is an infection control situation, and here are the triggers that allow us to get the information that we need. And I think it will take some time, but I think we can do it.

Unlike the Quebec example, this reporting obligation would presumably be imposed on both physicians and health care institutions. This expansion of the duty makes sense, since what might seem like a single case of illness to one doctor may be a cluster of cases to the person in charge of infection control or the hospital administration who is aware of a number of similar cases of illness.

However, the language suggested above remains problematic in that, while it is somewhat more precise than "public health risk," it is still difficult to define. For example, what is a cluster? What is the meaning of "unusual" or "adverse", what is the meaning of a "dangerous event"? And with a penalty on one side for nondisclosure and the fear of penalty on the other side for violating privacy legislation, the reporting party is left to navigate these imprecise terms without concrete guidance.

The reality is that reporting in these instances will only work if there is cooperation from those on the front lines, those in infection control programmes in health care institutions, and health care administrators and leaders. A physician or hospital who does not want to report will find refuge in the vagueness of the terminology. It is only where there is a desire to report, combined with certainty in the legal authority to disclose the personal health information, that the problem of alerting public health of health risks, actual or potential, will be addressed.

The first requirement, creating a desire to report, will come only if there is a strong relationship between public health and those with reporting obligations. As noted above, public health must have a presence within all aspects of the health care system, from family clinics to hospitals, to nursing homes and long-term care facilities. There must be a mutual relationship of respect and understanding of the important roles each side occupy. This can only be achieved if public health and hospitals each have the time, resources and manpower to establish and maintain these relationships.

If the physician or the health care institution can be convinced of the importance of reporting anything that may pose a public health risk, regardless of whether it is defined as a reportable disease or whether it neatly meets the definition of health hazard, they must be able to do so without any question regarding their legal ability to do so and without fear of violating privacy legislation.[138] That being the case, it is important to add to the *Health Protection and Promotion Act* a broad and expansive reporting power for health care practitioners and institutions. One public health expert succinctly described the value of such a provision:

> … one of the things was that physicians out in the field [during SARS] felt disenfranchised with the [reporting] process. If a doctor felt there was something that needs to be reported, they would like to be able to pick up the phone on an informal basis, to call and report. If for that they were reprimanded, lost hospital privileges or whatever, they could seek protection and say, well by law I could and I had grounds to do so.

Recommendations

The Commission therefore recommends that:

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[138] More will be said about the potential impact of privacy legislation on report in Chapter 7, Privacy and Disclosure.

- **The Ministry of Health and Long-Term Care, in consultation with the Provincial Infectious Diseases Advisory Committee, and the wider health care and public health communities, define a broad reporting trigger that would require reporting to public health where there is an infection control problem or an unexplained illness or cluster of illness.**

- **Whether or not a workable trigger can be defined for compulsory reporting, a provision be added to the *Health Protection and Promotion Act*, to provide that a physician, infection control practitioner or hospital administrator may voluntarily report to public health officials the presence of any threat to the health of the population.**

Investigation

Once armed with information, public health officials require sufficient authority to investigate the problem that has arisen in a health care facility or institution, whether it has been reported formally or has come to their attention through some other means. It goes without saying that hospitals and other health care institutions will try to deal with problems in the way they think best. The problem is that what is best for a hospital is not necessarily best for the public interest in protecting the health of the wider community. A mechanism is required to ensure that the public interest is protected in any case where the hospital's approach to an infection control problem or a potential infection outbreak may not adequately protect the public interest.

Take, for example, a cluster of unexplained illness within a hospital, of which public health becomes aware. What powers does public health have to require the hospital to conduct an epidemiological investigation or to conduct surveillance on staff and other patients? Under Part IV, Communicable Diseases, s. 22 empowers a medical officer of health to make orders related to communicable diseases.[139] However, to make such an order, the medical officer of health must, on reasonable and probable grounds, believe:

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[139] Section 22 provides:

Order by M.O.H. re: communicable disease

(1) A medical officer of health, in the circumstances specified in s. (2), may give directions in accordance with s. (3) to the persons whose services are engaged by or to agents of the board of health of the health unit served by the medical officer of health.

Subsection 24(2) provides:

When M.O.H. may give directions

(2) A medical officer of health may give directions in accordance with subsection (3) where the medical officer of health is of the opinion, upon reasonable and probable grounds, that a communicable disease exists in the health unit and the person to whom an order is or would be directed under section 22,

- that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health;
- that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and
- that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.[140]

The powers in s. 22 can be exercised only on a high standard of proof, the criminal standard of reasonable and probable grounds. In the above fact scenario, the medical officer of health may not yet have sufficient knowledge to form an opinion on reasonable and probable grounds. Moreover, the disease may be too new or too little understood to be listed by regulation as a communicable disease and may therefore be outside the scope of this section of the *Health Protection and Promotion Act*. The new disease might not even have a name, as was the case in the early days of SARS.

(a) has refused to or is not complying with the order;

(b) is not likely to comply with the order promptly;

(c) cannot be readily identified or located and as a result the order would not be carried out promptly; or

(d) requests the assistance of the medical officer of health in eliminating or decreasing the risk to health presented by the communicable disease.

Contents of Directions

(3) Under this section, a medical officer of health may direct the persons whose services are engaged by or who are the agents of the board of health of the health unit served by the medical officer of health to take such action as is specified in the directions in respect of eliminating or decreasing the risk to health presented by the communicable disease.

Idem

(4) Directions under this section may include, but are not limited to,

(a) authorizing and requiring the placarding of premises specified in the directions to give notice of the existence of a communicable disease or of an order made under this Act, or both;

(b) requiring the cleaning or disinfecting, or both, of any thing or any premises specified in the directions;

(c) requiring the destruction of any thing specified in the directions.

[140] See s. 22(2).

The powers in s. 22 do not give public health the necessary power to become involved with a hospital disease outbreak at the earliest stage, the crucial stage where there may still be time to stop its spread.

This is not to suggest that hospitals or other health care institutions would necessarily alert public health in the future should an unidentified disease enter its facility. In many jurisdictions public health has an ongoing relationship with the health care providers in their jurisdiction and there is a vital exchange of information that occurs on a continuous basis. But that is not the case with all institutions and with all public health units. And there is always the risk that fear of bad publicity, concern over panicking patients and visitors, or fear of civil litigation might cause a health care institution to report a risk to the public later rather than sooner. Or, they might attempt to handle the matter internally without involving public health officials. Add to this the fact that individuals and institutions now have to consider their potential legal liability and question the legal authority before they disclose personal health information to public health officials. Absent a clear legal authority to do so, many health care providers will likely have concerns about providing personal health information to public health and may opt to err on the side of nondisclosure rather than risk violating privacy laws. Public health must have the power to enter and investigate where there is a risk to the public, not just in those cases where the disease is communicable or where, in the hospital's own opinion, it determines it is necessary. The power must be set out in explicit statutory language to ensure that health care providers can be confident of their ability to cooperate in an investigation and to ensure that public health officials have the clear authority to compel cooperation from a dubious or reluctant institution.

An example of the type of power that is needed can be found in Part XI of Quebec's *Public Health Act*. Under that part, public health authorities have a number of powers to enable them to respond to a threat to the health of the population. Among those powers is the power to conduct an epidemiological investigation. Section 96 provides:

> 96. A public health director may conduct an epidemiological investigation in any situation where the public health director believes on reasonable grounds that the health of the population is or could be threatened and, in particular,
>
> 1) where the director receives a report of an unusual clinical manifestation following a vaccination under section 69;
>
> 2) where the director receives a report of an intoxication, infection or disease to which Chapter VIII applies;
>
> 3) where the director receives a notice under Chapter IX to the effect that a person is refusing, omitting or neglecting to be examined or treated or to comply with compulsory prophylactic measures;
>
> 4) where the director receives a report under Chapter X.

The relationship under this Quebec regime between public health and hospitals is two-way. Where an investigation reveals that a health threat had origins in a health care institution, or in a deficient practice, public health must notify the director of professional services or the executive director.[141] The section also requires that the institution must take all measures required as soon as possible to inspect its facilities and review its practices and, if necessary, correct the situation. The measures taken must be communicated without delay to public health authorities.

Section 100 of Quebc's *Public Health Act* sets out the powers of the public health investigator[142] and s. 106 sets out the powers of the public health director where, following the investigation, a "threat to the health of the population" is found to exist.[143] Section 104 makes it clear that cooperation must be given to the public health director to enable him or her to conduct an epidemiological investigation:

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[141] Section 99 provides:

> Health threat in health facility
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> A public health director who becomes aware during an epidemiological investigation that a threat to the health of the population appears to have its origin in a facility maintained by a health or social services institution or in a deficient practice within such an institution must notify the director of professional services or, if there is no such director, the executive director.

[142] Section 100 provides:

> Powers of public health investigator
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> Subject to s. 98, a public health director may, where required within the scope of an epidemiological investigation,
>
> 1) require that every substance, plant, animal or other thing in a person's possession be presented for examination;
>
> 2) require that a thing in a person's possession be dismantled or that any container under lock and key be opened;
>
> 3) carry out or cause to be carried out any excavation necessary in any premises;
>
> 4) have access to any premises and inspect them at any reasonable time;
>
> 5) take or require a person to take samples of air or of any substance, plant, animal or other thing;
>
> 6) require that samples in a person's possession be transmitted for analysis to the Institut national de santé publique du Québec or to another laboratory;
>
> 7) require any director of a laboratory or of a private or public medical biology department to transmit any sample or culture the public health director considers necessary for the purposes of an investigation to the Institut national de santé publique du Québec or to another laboratory;
>
> 8) order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential;
>
> 9) require a person to submit to a medical examination or to furnish a blood sample or a sample of any other bodily substance, if the public health director believes on reasonable grounds that the person is infected with a communicable biological agent.

[143] Section 106 provides:

> 104. Every owner or possessor of a thing or occupant of premises must, at the request of a public health director, provide all reasonable assistance and furnish all information necessary to enable the director to conduct an epidemiological investigation.

The Quebec legislation allows for a scaled response: inform, investigate and then act if required. A similar model of response is required for Ontario.[144]

Powers of public health director

Where, during an investigation, a public health director is of the opinion that there exists a real threat to the health of the population, the director may

1) order the closing of premises or give access thereto only to certain persons or subject to certain conditions, and cause a notice to be posted to that effect;

2) order the evacuation of a building;

3) order the disinfection, decontamination or cleaning of premises or of certain things and give clear instructions to that effect;

4) order the destruction of an animal, plant or other thing in the manner the director indicates, or order that certain animals or plants be treated;

5) order the cessation of an activity or the taking of special security measures if the activity presents a threat for the health of the population;

6) order a person to refrain from being present for the time indicated by the public health director in an educational institution, work environment or other place of assembly if the person has not been immunized against a contagious disease an outbreak of which has been detected in that place;

7) order the isolation of a person, for a period not exceeding 72 hours indicated by the public health director, if the person refuses to receive the treatment necessary to prevent contagion or if isolation is the only means to prevent the communication of a biological agent medically recognized as capable of seriously endangering the health of the population;

8) order a person to comply with specific directives to prevent contagion or contamination;

9) order any other measure the public health director considers necessary to prevent a threat to the health of the population from worsening or to decrease the effects of or eliminate such a threat.

[144] The Commission is recommending that powers similar to those found in Quebec's *Public Health Act* be added to the *Health Protection and Promotion Act*. There are, however, portions of the *Public Health Act* that the Commission would not support. For example, s. 107 provides:

> 107. Notwithstanding the provisions of s. 106, a public health director may not use a power provided for in that section to prevent a threat to the health of the population from worsening or to decrease the effects of or eliminate such a threat if a government department, a local municipality or a body has the same power and is able to exercise it.

Some question whether our public health system has the capacity to enter and provide infection control direction to health care institutions, particularly well-known teaching hospitals with renowned staff experts in infection control. One public health official questioned whether public health has the necessary technical expertise:

> I'm concerned, if we're given the statutory authority to demand actions on the part of hospitals where we consider that there's an issue, a problem, a substandard approach to an infection control issue, whether we have at this point in time the full skill set related to infection control, especially with the myriad of complexities in some of our larger acute care institutions … To give us the authority to demand action without the skill and resource base to do that may be a recipe for credibility issues, for a less fulsome success as could be the case. And I'm wondering if there isn't a parallel but separate mechanism like the Provincial Infectious Diseases Advisory Committee to increasingly establish what are the standards of practice, the expectations, the evidence based practice dimensions of an increasingly comprehensive approach to infection control; and then the resources, the human resources, the skills, the protocols the audits, monitoring capabilities and then the sanctions, the requirements to comply with these increasingly comprehensive and specific infection control standards of practice. This puts less of the onus on us. I'm impressed and humbled by the complexity of that terrain [infection control] and in my training, most if not all of our training, we just don't get the exposure to a sufficient level of detail nor the opportunity and the resources to maintain a currency with development in the evidence related to infection control that we would need to be truly credible and competent directors, requirers of action if we feel that something is not up to snuff.

This is a legitimate point. Public health must invest in the scientific and professional capacity necessary both locally and provincially to provide meaningful expertise and advice to health care facilities and institutions. For long-term issues, protocols, policies and directives, the province has a tremendous resource in the Provincial Infection Diseases Advisory Committee (PIDAC),[145] with its multi-disciplinary approach and wide spectrum of

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It is difficult to understand the rationale behind this section. The Chief Medical Officer of Health, with her political independence and obligation to speak and act on behalf of the health of the public of Ontario, and local medical officers of health who have similar obligations, are best positioned to determine when and where to act. The fact that another politician or official may have similar powers should not detract from the power available to public health officials.

[145] PIDAC's Main Committee consists of the following members:

Co-Chairs	
Dr. David Williams	Medical Officer of Health – Thunder Bay District Health Unit
Dr. Dick Zoutman	Director of the Joint Infection Control Service Chief of the Joint Microbiology Services Attending Physician, Infectious Diseases Service Kingston General, Hotel Dieu, and St. Mary's of the Lake Hospitals and the South Eastern Ontario Health Sciences Center

Members	
Anne Bialachowski	Infection Control Practitioner Hamilton Health Services Centre, Hamilton General Hospital
Dr. Maureen Cividino	Occupational Health Physician St. Joseph's Hospital, Hamilton
Dr. Gary Garber	Head of Infectious Diseases Ottawa Hospital
Dr. Ian Gemmill	Medical Officer of Health Kingston, Frontenac and Lennox and Addington Health Unit
Dr. Colin Lee	Associate Medical Officer of Public Health Simcoe County District Health Unit Staff Emergency Physician, Royal Victoria Hospital of Barrie
Dr. Anne Matlow	Director, Infection Prevention and Control The Hospital for Sick Children, Toronto
Dr. Chris O'Callaghan	Project Coordinator, NCIC Clinical Trials Group Assistant Professor, Queen's University
Dr. Mary Vearncombe	Medical Director, Infection Prevention and Control Sunnybrook and Women's College Health Sciences Centre
Ex Officio	
Dianne Alexander	Manager, Policy Planning and Coordination Community Health and Acute Services Divisions Ministry of Health and Long-Term Care
Dr. Karim Kurji	Associate Chief Medical Officer of Health Ministry of Health and Long-Term Care
Dr. Frances Jamieson	Medical Microbiologist Clinical and Environmental Microbiology Department Ministry of Health and Long-Term Care
Dr. Sandy Nuttall	Manager (A) Hospital Policy and Funding Unit Hospitals Branch, Ministry of Health and Long-Term Care
Allison J. Stuart	Director, Emergency Management Unit Ministry of Health and Long-Term Care

Terms of Reference – PIDAC

Mandate

The Provincial Infectious Diseases Advisory Committee (PIDAC) advises Ontario's Chief Medical Officer of Health with respect to the prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases. PIDAC provides expert advice relevant to both ongoing and emerging infectious disease issues.

Activities

Activities of PIDAC include the following:

- Reviewing and recommending the revision of provincial standards and guidelines for infection control, including but not limited to comprehensive infection control programs, human resource requirements, infection control training and education, and specific infection control protocols and procedures.
- Preparing advisory statements and bulletins for health care providers, to address new infection control developments or infectious disease issues of provincial significance, as they arise.
- Collaborating with appropriate academic, research and professional bodies in the development of such things as core indicators, audit tools, model infection control protocols or programs, and any other product, tool or document at the request of the Chief Medical Officer of Health.

expertise, to play the role of advisor and expert. But no advisory committee can supply the operational resources required to respond to immediate problems in the field that require speedy investigation and intervention. As another public health official noted:

> … certainly within public health there is a level of expertise and we may not know all the ins and outs of infection control within the [different hospital] units, but we know if there's a problem. We can then ensure the protection of the patients that are also entering [a hospital] who will then subsequently be discharged in 48 hours out back into the community.

Another health expert, asked how to deal with major teaching hospitals whose level of infectious disease expertise may surpass that of public health, said:

> My response to that would be work towards the majority. We have five or six major centres in this province where they probably have an infection

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- Reviewing and advising upon:
    - specific areas of infectious disease control, including surveillance;
    - infection control and infectious disease research priorities;
    - educational programmes about infectious diseases for both health professionals and the public;
    - proposed changes to existing provincial legislation and regulations related to infectious diseases;
    - infectious disease protocols and guidelines;
    - immunization issues;
    - emergency preparedness issues, including emergency response protocols or contingency plans, as the need arises.
- Advising upon relevant infection control and infectious disease policy, at the request of the Chief Medical Officer of Health.
- Reviewing regularly the regulations under the Health Protection and Promotion Act which designate Communicable, Virulent and Reportable Diseases.
- Reviewing regularly communicable disease surveillance protocols published jointly by the Ontario Hospital Association and the Ontario Medical Association, pursuant to subsection 4(2) of Regulation 965 under the Public Hospitals Act.

Membership

Membership of PIDAC includes individuals chosen for their expertise in the areas of epidemiology, public health, infection control, medical microbiology, adult infectious disease, paediatric infectious disease, occupational health and safety, zoonotic disease and primary care, as well as Ministry of Health and Long-Term Care representatives (ex officio).

Members are appointed to PIDAC in writing for a three-year term by the Chief Medical Officer of Health. Sitting members may be reappointed for additional terms of three years each. After ceasing to be a PIDAC member, an individual may serve as a member of a subcommittee or on a working group as requested.

> control person who is world renowned and knows a hell of a lot more than just about any other person. But we also have, if you want to include all the long-term care facilities that these guys have to deal with, hundreds of facilities out there, most of which have someone who has got sixteen hours out of grad school under their belt and they have been thrown into an infection control management position and quite honestly if the academic centres want to complain about having a two or three years out of grad school person come in and point fingers, let them complain. They might not be happy to hear me say that but you have to work towards what is out there and the majority of the situations are really poor or lacking or needing direction in the kind of programmes going on and I think we need to look at the larger population needs as opposed to the academic science centres.

SARS demonstrated that hospitals and other health care facilities are not isolated institutions operating on their own. Events that occur in one hospital may have implications for the broader public health. In those cases, public health must have the knowledge and power to monitor and, where necessary, intervene to ensure that the protection of the public is paramount.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to include powers similar to those set out in Quebec's *Public Health Act*, to allow for early intervention and investigation of situations, not limited to reportable or communicable diseases, that may pose a threat to the health of the public.**

Case Classification

During SARS, the classification of cases as suspect or probable was the responsibility of local medical officers of health. Since SARS was a reportable disease under the *Health Protection and Promotion Act*, physicians and hospitals were legally required to report new cases to the local medical officer of health.[146] The local medical officer of health, in turn, had a corresponding duty under the Act to report new cases to the province,[147] as either a probable or suspect case of SARS. This was a heavy burden because of the impact of a mistake. Missing a case could lead to further spread of the disease. A false-positive diagnosis, on the other hand, could unnecessarily close hospitals, schools, public buildings and other workplaces and quarantine large numbers of people. It could also have consequences on the world stage where the World Health Organization was closely monitoring the situation in Ontario.

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[146] Pursuant to s. 25(1) and 27(1) of the *Health Protection and Promotion Act.*

[147] Pursuant to s. 31(1) of the *Health Protection and Promotion Act.*

Because SARS was such a difficult disease to diagnose, because there were no reliable lab tests, and because knowledge about the disease was rapidly evolving on a daily basis, there were disagreements from time to time between the reporting institution and public health officials as to whether a particular case was a case of SARS. It was critical that each SARS case be recognized and reported. It was equally vital that every non-SARS respiratory infection not be classified as SARS simply as a precaution.

In May 2003, a central "adjudication" system under the apparent authority of the Chief Medical Officer of Health sprang up in an attempt to resolve disputes over classification of cases. The Commission described the adjudication system and the concerns surrounding it, in the Commission's first interim report, under the heading "Lack of Transparency:"

> [beginning of quote]
>
> There clearly was a need to ensure accuracy and consistency of classification and reporting of cases. Having regard for the challenges of making a correct diagnosis, it made sense to set up a case review system to assist local medical officers of health by giving them access to SARS experts. Although well meaning, the adjudication system lacked clear lines of accountability and in particular it lacked transparency.
>
> First, the adjudication system appeared to supplant the decision-making of the local medical officers of health. There was no explanation why, well over a month into the outbreak, the adjudication process was suddenly imposed.
>
> Second, the adjudication system was not clearly defined or explained. A May 2nd memorandum from Dr. D'Cunha, the Chief Medical Officer of Health, to all medical officers of health and associate medical officers of health simply stated:
>
> > Effective immediately, all new, potential "probable cases" of SARS require adjudication by the POC.
> >
> > If a potential probable case is identified in your jurisdiction or circumstances would indicate reclassification of an existing suspect case to a probable case, you are to contact [name and number of contact person] to make arrangements for a chart review.
> >
> > Please be prepared to forward by courier the copies of all relevant information, including clinical information and copy/s of x-ray/s to the infectious disease consultant on call that day.
> >
> > Thank you for your cooperation.
>
> It was unclear in the memo how the adjudicators were chosen, or why they were best qualified to make decisions. While the name and telephone number of a contact person were provided in the memo, many medical

[continuation of quote]

officers of health did not know the person and were unfamiliar with their qualifications, position, role, and authority. Moreover, they did not know who would receive any confidential personal health information about a possible SARS case, where this information would go, how many people would have access to it and whether they had a right to it. The local medical officer of health did not know what would happen if they did not accept the advice of the adjudicator or who had the final call. The local medical officer of health did not know who would be accountable and bear the ultimate legal responsibility if they changed their initial classification of a case based on advice given through the adjudication process.

How the adjudication system was to be implemented was unclear. Was it to be voluntary in that the medical officer of health could resort to it for advice but was not required to do so? Or was it mandatory in the sense that all new SARS diagnoses had to be screened through this process? The use of the word "adjudicate"[148] and the wording of the May 2nd memo suggests that it was to be mandatory. If this was the case, wondered many local medical officers of health, what was the legal authority for the adjudication process?

One medical officer of health described it as follows:

> An adjudication process was introduced that was designed that any listing of a new probable case had to go through a case review by the provincially selected infectious disease specialist. They were to gather all the chart information from the hospital. They would not have the epi information that was in the public health charts on whether this was a case or not – a probable or suspect case, and submit a report in writing to the POC or SOC, it was never described who they would report it to, and then we were supposed to accept this benignly.

The concerns of medical officers of health sometimes rose to serious levels of mistrust. Many were troubled by the fact that the adjudication process was imposed two days after the WHO travel advisory had been lifted. More will be said about the adjudication process and the classification of cases in the final report. Suffice it to say that the lack of transparency in the adjudication system led to confusion over roles and responsibilities and created the perception among some that local medical officers of health were being muzzled by the province.

In a widespread public health system with 37 different local medical officers of health, it makes sense during an infectious disease outbreak to have some central system to ensure as much as possible the accuracy and consistency of

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[148] The Canadian Oxford Dictionary defines adjudicate as: "Act as judge in competition, court, tribunal, etc."

> [continuation of quote]
>
> local decisions to designate a case as a reportable disease. The difficulty with the adjudication system during SARS comes down again to lack of planning and preparedness. There was no time to plan or consult before imposing a system that inevitably, because it sprang up overnight, attracted all the problems associated with lack of prior consultation and lack of transparency.
>
> To avoid this problem in the future the Commission recommends that the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding whether a particular case should be designated as a reportable disease, should be clarified and regularized in a transparent system authorized by law.[149]
>
> [end of quote]

For many local medical officers of health, the system was suspect, coming months into the SARS outbreak, shortly after the imposition and subsequent lifting of the travel advisory, with little explanation or rationale for the system itself and without transparency in the process or the identity of those who would make the decisions. For example, what expertise did the adjudicator have that made their classification more reliable than that of the local medical officer of health? How the adjudication system was to be implemented was unclear. Was it to be voluntary in that the medical officer of health could resort to it for advice but was not required to do so? Or was it mandatory in the sense that that all new SARS diagnoses had to be screened through this process? If it were mandatory, did the overriding party assume and bear all accountability in the event their decision was wrong? It was unclear under what authority in the *Health Protection and Promotion Act* the Chief Medical Officer of Health could override the discretion of the local medical officer of health? The only answer appears to lie in ss. 86(1) and (2) which provide:

> 86(1) If the Minister is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.
>
> (2) For the purpose of subsection (1), the Minister,
>
>> (a) may exercise anywhere in Ontario any of the powers of a board of health and any of the powers of a medical officer of health; and
>>
>> (b) may direct a person whose services are engaged by a board of health to do, anywhere in Ontario (whether within or outside the health unit served by the board of health), any act,

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[149] The Commission's first interim report, pp. 49-51.

> (i) that the person has power to do under this Act, or
>
> (ii) that the medical officer of health for the health unit served by the board of health has authority to direct the person to do within the health unit.

But this is an awfully blunt tool. In a widespread public health system with 36 different local medical officers of health, it makes sense during an infectious disease outbreak to have some central system that ensures as much as possible the accuracy and consistency of local decisions to designate a case as a reportable disease. Furthermore, not all medical officers of health may feel that they have sufficient expertise about a particular disease to classify a case. Consider the case of SARS. During March, April, May and June of 2003, there were a number of brave and dedicated physicians in the greater Toronto area had been involved in the diagnosis and care of many SARS patients. Had SARS spread to a smaller community outside the greater Toronto area, the physicians in that community, including the local medical officer of health, could undoubtedly have benefited from the depth of their colleagues' experience and knowledge. In such a case one might expect that the Chief Medical Officer of Health would intervene and assist or ensure that the local medical officer of health had the benefit of the expertise available from outside their jurisdiction.

But the process by which this would occur must be clearly established in advance and it must be clear how it may be initiated. The respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding whether a particular case should be designated as a reportable disease, should be clarified and regularized in a transparent system authorized by law. As one submission to the Commission stated:

> There needs to be clarity with respect to who has authority to designate cases of infectious disease in an outbreak situation; what lines of authority are in such instances; and who has the responsibility for making the final determination.

It is unlikely that the power and process by which cases are classified will become an issue on a day to day basis. However, should an outbreak of an infectious disease occur, the same issues that arose during SARS regarding the classification of cases will undoubtedly surface again. Now, in the aftermath of the outbreak, is the time to address the issue and implement a clear process should the need arise to adjudicate the classification of cases in the future.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to clarify and regularize in a transparent system authorized by law, the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding how a particular case should be classified.**

Directives

During SARS, directives were issued to hospitals and other health care providers under the signature of the Chief Medical Officer of Health, Dr. D'Cunha, and the Commissioner of Public Safety and Security, Dr. Young.[150] They differed from orders under s. 22 of the *Health Protection and Promotion Act* in that they were issued across the province, broadly targeting hospitals and other health care providers. They were not issued based on individual criteria and circumstances, but rather they were general directives to health care providers that required particular procedures and precautions in the management of SARS cases and the prevention of its spread.

While many privately questioned the authority of either group to make blanket orders to hospitals and other health care facilities, regardless of whether they met the criteria for an order under s. 22 of the Act, for the most part health care facilities and hospitals complied, leaving aside legal uncertainty in the spirit of cooperation. Post-SARS, directives have continued to be issued directing health care facilities on issues ranging from infection control to surveillance and case management.

Even now that SARS is over, the question remains: under what legal authority were these directives issued and under what authority are they continued and replaced by new directives?[151] Many directives were issued across the board to all hospitals whether they had SARS cases or were even within the greater Toronto area. How would those hospitals without SARS cases, remote from the greater Toronto area, fit the requirement under s. 22 that a "communicable disease exists or there is an immediate risk of an outbreak of a communicable disease in the health unit"? Legal arguments can be made for and against the authority of the Chief Medical Officer of Health to issue such directives under s. 86 of the *Health Protection and Promotion Act*. It may be that a generous reading of the *Health Protection and Promotion Act* could support the legal authority for the directives issued to hospitals during and after SARS.

There is too much at stake to leave this vital issue to a debate between lawyers about strict and generous interpretations of the *Health Protection and Promotion Act*. The law must be clear. The Chief Medical Officer of Health must have the clear power to issue directives to health care facilities and institutions on issues related to the prevention and control of infectious diseases to ensure a uniform and adequate standard of public health protection within the health care field as a whole. One undetected or unreported case of an infectious disease may have disastrous consequences for the public's health. One health care facility with substandard procedures or poor infection control could be the site where the index patient of a new disease seeks treatment and spreads the deadly virus. The province, through the Chief Medical Officer of Health after appropriate consultation with the appropriate experts and health care communities, must have the authority to direct and ensure an appropriate level of institutional protection against infectious disease.

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[150] For example: Directive 03-01, Directives to all Ontario Acute Care Hospitals, April 1, 2003; Directive L03-03, Directives to all Ontario Non-Acute Care Facilities for Admissions and Transfers from Hospitals of Non-SARS Patients, April 11, 2003.

[151] For example: Directive PHCO03-01, Directives to all Pre-Hospital Care Providers and Ambulance Communications Centres Regarding Management of Patients with Possible Communicable Diseases Including SARS under Outbreak Conditions, December 7, 2003; Directive HR04-13, Directive to all Ontario Health Care Facilities/Settings for High-Risk-Aerosol-Generating Procedures Under Outbreak Conditions, April 15, 2004.

The Chief Medical Officer of Health must be able to issue directives on a broad range of issues in respect of the prevention and control of infectious diseases, applicable across the province or directed at specific types of institutions or specific areas of the province. One public health official noted the importance of this power:

> … there have been instances from time to time when a piece of contaminated equipment has been identified or a manufacturer's malfunction has been identified and it can't be properly sterilized and that's only discovered after the fact. And it would be really helpful to have clear authority from the Chief Medical Officer of Health in those instances to issue directives, rather than the present way of working through the bureaucracy in a way that is not efficient.

It is imperative that hospitals and other health care institutions, both private and public, have clear direction as to the legal authority of the directives and the potential consequences of noncompliance. As one hospital wrote the Commission:

> Under the *Public Hospitals Act*, a hospital must be governed by a board of directors, who have certain enumerated responsibilities and duties, in addition to the broad common law duty to govern in the best interest of the hospital corporation. Given this model of hospital governance, it may be expected that hospital board members would query directives emanating from a central body, particularly where such directives require the hospital to implement new services, discontinue existing services, or completely reorganize the delivery of such services. Therefore, any special health emergency legislation that provides for a centralized authority, external to hospitals, with the power to issue directives, must also make clear the legal force of such directives and the consequences to members of the health care sector for departing from them.

Accountability requires that all directives be issued under one single authority. As one hospital said:

> During a declared Provincial Emergency, a single authority should be designated for the purpose of issuing guidance to health care organizations. Each action communicated to health care organizations by this authority should be clearly labelled as to whether the action is mandatory, recommended or discretionary.

The Commission recommends that all directives be issued under the signature of the Chief Medical Officer of Health. The independence and medical expertise associated with that office make it the best single source of directives. The directives of the Chief Medical

Officer of Health would of course be informed by the best advice of other health care professionals and medical experts. But at the end of the day the directives come under the signature of the Chief Medical Officer of Health alone and the holder of that office bears full accountability.

The power to issue directives is distinct from the power to issue orders under s. 22 of the Act. The power to issue directives should provide explicitly that it does not derogate from the existing power under s. 22.

To support this enormous responsibility it is essential that the Chief Medical Officer of Health have the scientific support and resources to administer a timely system of directives. These directives must reflect the best scientific advice and the best operational advice on how they should be organized and expressed to make them understandable and practical in the field. The directive system used during SARS was hampered by the fact that it was thrown together quickly without the time or resources necessary to ensure that the directives made immediate sense to those administering them in the emergency rooms, hospital wards and medical floors of the hospitals. It would be unfair and dangerous to assign this task to the Chief Medical Officer of Health without the resources to carry it out. Should this occur, the Commission would expect that the only recourse available to the Chief Medical Officer of Health would be to exercise her independence and speak out publicly to alert the public and health care providers of the situation and the clear risk that such an event would pose to the public's health.

As noted above it is vital to ensure that the directives are not only medically sound but that they are also capable of being followed in a practical manner. The Commission has heard repeatedly from various members that the directives sent during SARS and post-SARS are lengthy and unwieldy for practitioners. As Dr. Larry Erlick of the Ontario Medical Association said in the Commission's Public Hearings:

> The directives that were produced by the provincial operations center or POC during the height of the emergency, suffered immeasurably from a lack of simple practicality. These directives did not work from a hands-on clinical perspective. The disparity between what will function academically and practically during an emergency became obvious in these directives.[152]

One physician provided a stark example to the Commission of a directive that spanned over many pages, which the chief of staff at his hospital had to reduce to one page, so that emergency room physicians could review and absorb the main message in a timely fashion. As he described it to the Commission:

> Here are current directives for respiratory illness during emergency [holds up thick document]. And here's what our Chief of Emerge did when trying to sort out what to do [holds up one sheet of paper]. When we get a directive from the MOHLTC it is pages and pages of stuff and buried in there is what

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[152] SARS Commission, Public Hearings, September 29, 2003.

> is important. Practicing physicians cannot cope with this. It is too much. These are final ones, dated March/04, not the kinds we were getting in March and April 03 which where changing all the time. I cannot read that in less than one hour and make sure I've got it straight. When there is a central body that wants to give directives that central body, whatever it is, whoever makes directives, there has to be a receiving person for all the different types of professionals, a receiving nurse or receiving community based physician, who is responsible for rewriting them in the language of receivers. This one page document from the Chief of Emerge works for me. It speaks my language. But to a public health nurse it won't mean anything. I don't know who can read the directives well. I can do it if I take an afternoon off and have no distractions. But it is nuts for every single practicing physician in the community to have to do that. What a waste of resources. It is appropriate to have various receiving leaders for whom the directive is designed, area experts to rewrite directives in the receivers' language because we all use different language, then show it to the decision makers and say is this what that says, and then use it.

Another hospital wrote:

> If directives are to be the mechanism for the centralized authority to direct the activities of the health care sector during an emergency, such directives should be written in clear and unambiguous language so that the recipients are equally clear as to the measures that are to be taken, and whether the directives are permissive or mandatory.

It was an incredible waste of time and energy during SARS that each institution had to take the directives and translate them individually into accurate messages that their staff could quickly learn and retain.

The Commission recommends the appointment of a working group comprised of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by the directives knows how they work, what they mean and how they should be applied. There is often room for different interpretations of medical directives and it is essential that they be applied consistently to ensure that the hospitals throughout Ontario take the same message and apply it in the same way. This group would be tasked with the additional responsibility of overseeing the education of health care professionals about the directives, to ensure that regardless where the health care institution was situated, the directives were being applied consistently.

It is not enough to ensure that the directives are medically sound and are vetted to make them understandable and workable in the field. Understanding and workability require active feedback machinery. Even the most exquisitely crafted directives require a regular reality check to ensure they are properly understood and practically workable in the field and that they are in fact clear and manageable. The enormous experience and wisdom of the nurses and doctors and other health care workers in the field will be wasted if not incorporated into a simple feedback system driven by those whose job it is to make the directives work in practice.

As Dr. Larry Erlick of the Ontario Medical Association told the Commission:

> Another area of deep concern was that POC was established with little or no capacity to hear feedback or suggestions from affected stake-holders. On some occasions, only when we refused to distribute confusing or incorrect directives, were we finally able to get a hearing to our concerns and make suggestions for improvement.[153]

On a cautionary note, it must be understood that the directives are addressed to specific public health concerns and expressed in a general way that applies to health care facilities across the province or, in the case of a limited direction, a substantial number of facilities. The directives represent the minimum that needs to be done to protect public health. The directives do not in any way diminish the standard of care ordinarily required by the circumstances that prevail in any particular institution. The directives represent the floor, not the ceiling, of medical precaution. They do not relieve any institution of the obligation to take further precautions where medically indicated. As one hospital wrote to the Commission:

> Recommendations from the Minister should represent the minimum standards in an evolving situation when it is not always clear what the minimum should be. For example, it is now known that SARS is airborne as well as droplet and contact mode of transmission. Therefore institutions should be required to meet the recommendations of the Provincial Medical Officer of Health, but free to implement additional precautions as deemed necessary in such situations, for example use of two gowns versus one gown, a hood versus a head covering etc.

Another cautionary note is that for the directives to be effective there must be some machinery of enforcement. Any enforcement mechanism to be workable requires consultation with, and input from, health care facilities and private clinics, as well as a means by which the Public Health Division can audit those to whom the directives are targeted to ensure compliance. The Commission therefore recommends that the Ministry of Health and Long-Term Care consult the affected health care communities with a view to developing effective machinery to enforce directives.

Recommendations

The Commission therefore recommends that:

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[153] *Ibid.*

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to issue directives to hospitals, medical clinics, long-term care facilities, and all other health care providers, private or public, in respect of precautions and procedures necessary to protect the public's health. All directives should be issued under the signature of the Chief Medical Officer of Health alone.**

- **The Ministry of Health and Long-Term Care appoint a working group of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by the directives knows how they work, what they mean and how they should be applied.**

- **The Ministry of Health and Long-Term Care, in consultation with the affected health care communities, develop feedback machinery driven by health care workers in the field, to ensure the directives are clear and manageable from a practical point of view in the field.**

- **The *Health Protection and Promotion Act* and the directives provide explicitly that they in no way diminish the procedures and precautions required by the circumstances that prevail in any particular institution, that they represent the floor, not the ceiling, of medical precaution, and do not relieve any institution of the obligation to take further precautions where medically indicated.**

Power to Detain

Freedom from arbitrary detention is a social value of superordinate importance. Detention must be clearly authorized by law and accompanied by safeguards. It has proved necessary to grant, sparingly, powers of detention and arrest in cases clearly required by the public interest, such detention to be followed by an early opportunity to challenge the detention in a court of law. The realities of the risk posed by a virulent disease require a narrow zone of power to detain individuals who present a clear danger to the public's health. While such power must be protected with legal safeguards, the community cannot shirk its obligation to detain, however briefly it may be necessary, those who threaten the safety of the entire community. The power to detain necessarily carries with it the power to arrest. The power to detain temporarily an infectious person, unless ultimately backed up by the power to arrest in those rare cases where the detainee refuses to cooperate, has no practical force.

The issue of detention arises in a number of possible scenarios:

- Brief detention for the purpose of identification;

- Detention for the purpose of decontamination; and
- Detention for the purpose of examination, treatment, isolation or to prevent the spread of disease.

Currently, the *Health Protection and Promotion Act* only deals with the third scenario, detention for the purposes of treatment or isolation in respect of a virulent disease. Under s. 35(3) of the Act, a judge may order a person who fails to comply with an order of a medical officer of health detained:

> 35(3) In an order under this section, the judge may order that the person who has failed to comply with the order of the medical officer of health,
>
> (a) be taken into custody and be admitted to and detained in a hospital or other appropriate facility named in the order;
>
> (b) be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and
>
> (c) if found on examination to be infected with an agent of a virulent disease, be treated for the disease.

An order under s. 35(3) can be made only for noncompliance with an order made under s. 35(2) in relation to a communicable disease that is virulent. Subsection 35(2) provides:

> An order may be made under subsection (3) where a person has failed to comply with an order by a medical officer of health in respect of a communicable disease that is a virulent disease,
>
> (a) that the person isolate himself or herself and remain in isolation from other persons;
>
> (b) that the person submit to an examination by a physician;
>
> (c) that the person place himself or herself under the care and treatment of a physician; or
>
> (c) that the person conduct himself or herself in such a manner as not to expose another person to infection.

One gap in the law is the lack of machinery for the rare situation where public health authorities need urgently to take the name and address of someone who may have come into contact with an infectious disease. Take for instance the closing of a hospital because an infectious disease outbreak within the hospital appears to be running out of control. It is necessary to identify all those leaving the hospital when it is closed. Otherwise there is no way to ensure that they have not become carriers into the community of a deadly disease. Most people leaving a hospital in these circumstances will cooperate and provide to public health authorities their name and address and telephone number. But for those few who refuse to cooperate, those who decline to stop on their way out, and decline to give their name and address for the purpose of contact tracing, clear authority is required to enforce cooperation. There is now no authority to stop and require identification from people leaving places of infection.

Without this authority it may be impossible to ensure the appropriate follow-up of those who may spread a deadly infection to the community, and indeed to their own families.

It would better protect the public if public health authorities have the power to detain briefly and to require identification from anyone leaving a place of infection or suspected infection. One observer described the importance of this temporary power of detention which would have to be backed up with the possibility of arrest and police assistance in cases of non-cooperation:

> The idea is not so much to detain them as to make sure you know who was there at any point in time. If they all walk out and scatter and run home you inadvertently expose all their families when we have nothing sorted out in terms of who was there. It takes sixteen times as long to sort out who was there, if they don't identify themselves before they leave.

The Commission therefore recommends that the *Health Protection and Promotion Act* be amended to provide authority to public health officials to detain temporarily for the purpose of identification anyone who refuses to provide their name and address and telephone contact information when required to do so for the purpose of identifying those who are leaving or have been in a place of infection, this power to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

The next legal gap to consider is the lack of any authority to detain for the purpose of decontamination.

Dr. Henry, testifying before the Justice Policy Committee, described the need for this power in relation to an anthrax threat. She stated:

> I think we need to look at some authorities that we may need to have. One of the issues we ran into when we were dealing with suspicious packages – and you may notice that we haven't actually evacuated Queen's Park for quite some time because we put together a very coordinated response to this. But the questions arise. Somebody receives a threat in an office, a credible threat with a powder in it; they're covered in white powder and they panic and they want to go home. We currently have no authority to detain that person: the police do not and the medical authority does not. We can probably fake it and try and convince them to stay, but they could pose a danger to other people. They don't fit into the communicable disease sections because

> they're not actually sick with the disease, and they don't fit into the police sections at the moment. So we need to think about these situations."[154]

Similarly, public health officials have noted the need for a power akin to the quarantine power, to decontaminate individuals or groups who may have been exposed to a health risk that poses a threat to themselves or to the public. Classic examples include exposure to a white anthrax-like powder or nuclear contamination. Dr. Basrur told the Justice Policy Committee:

> … if you have a white powder exposure and a whole lot of people covered with stuff, and you don't want them all heading home because they're scared, and some of them go on the subway and some go to the parking lot, you need an ability to detain them, but it's not necessarily an infectious agent that they've got on them. They need to be decontaminated, counselled, their whereabouts identified, and then sent home, with follow-up.[155]

The Ministry of Health also pointed out the need for authority in respect of:

> Decontamination in emergency situations, where such action is considered appropriate (decontamination orders are not currently found under the Act, but such procedures may be required for individuals or large groups in the event of a nuclear disaster.)[156]

Like isolation orders and treatment orders, the power to decontaminate must include the power to detain at least temporarily for the purpose of a court hearing, those who refuse voluntary decontamination. Otherwise, an exposed person could simply refuse, walk away, and expose countless members of the public. However, unlike the power to detain temporarily for the purposes of identification or to detain for the purposes of obtaining a s. 35 order, the power to detain for decontamination purposes implies that the power to decontaminate is part and parcel of the detention. But what does it mean to decontaminate someone? The U.S. Army's "Guidelines for Mass Casualty Decontamination during a Terrorist Chemical Agent Incident" describes the following decontamination process:

> Decontamination by removing clothes and flushing or showering with water is the most expedient and the most practical method for mass casualty decontamination. Disrobing and showering meets all the purposes and principles of decontamination. Showering is recommended whenever liquid transfer from clothing to skin is suspected. Disrobing should occur prior to showering for chemical agents; however, the decision to disrobe should be made by the Incident Commander based upon the situation. Wetting down

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[154] Justice Policy Committee, Public Hearings, August 18, 2004, p. 149.

[155] *Ibid*, p. 160.

[156] Letter to Mr. Doug Hunt, Q.C., Commission Counsel, from Mr. Phil Hassen, Deputy Minister of Health and Long-Term Care, August 4, 2004. See Appendix H to this Report.

> casualties as they start to disrobe speeds up the decontamination process and is recommended for decontaminating biological or radiological casualties. However, this process may:
>
> - Force chemical agents through the clothing if water pressure is too high.
> - Decrease the potential efficacy of directly showering skin afforded by shear forces and dilution.
> - Relocate chemical agent within the actual showering area, thereby increasing the chance of contamination spread through personal contact and shower water runoff.
>
> The MCDRT recommends that victims remove clothing at least down to their undergarments prior to showering. Victims should be encouraged to remove as much clothing as possible, proceeding from head to toe. Victims unwilling to disrobe should shower clothed before leaving the decontamination area. It is also recommended that emergency responders use a high volume of water delivered at a minimum of 60 pounds per square inch (psi) water.[157]

This is clearly more intrusive than asking someone for identification or detaining someone for a defined period of time pending a court order for treatment. The power to decontaminate must be considered separate and apart from the power to detain for such purposes. It must be clear what decontamination means, who can order it and under what circumstances, and the nature of the consequences for refusal. Like the power to order treatment, forcing someone to undergo decontamination should only be done pursuant to judicial authorization.

Similarly, the following passage, taken from Jane's Chem-Bio Handbook,[158] a well-informed, practical handbook for first-responders on the scene of a suspected bioterrorist attack, underlines the operational necessity of being able to detain and decontaminate people:

> Some victims may become agitated and fearful and may attempt to either leave the exclusion zone (the zone containing special response personnel in PPE and victims, which is cordoned off from public access. Also known as the hot zone.) or approach, or even contact, rescue personnel. Victims must be contained if risk of further contamination is to be prevented.[159]

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[157] U.S. Army Soldier and Biological Chemical Command (SBCCOM), "Guidelines for Mass Casualty Decontamination During a Terrorist Chemical Agent Incident," January 2000.

[158] Sidell, Frederick R, Patrick, William C, Dashiell Thomas R, Alibek, Ken, Layne, Scott, *Jane's Chem-Bio Handbook* (Jane's Information Group Alexandria, Virginia: 2002).

[159] *Ibid*, p. 17.

The power to detain is necessary for those who do not agree voluntarily to the decontamination process. Otherwise an infectious person could simply refuse, walk away, and spread the contaminant. And the power to detain for decontamination, like the power to detain for identification, must have the ultimate backup of an arrest power and police assistance if it is to work on those who refuse to cooperate. Because decontamination is akin to a medical procedure it must, in those cases where consent is refused, operate in conjunction with a legal process to secure judicial authorization before a person may be compelled to submit to decontamination. The power to detain and isolate someone pending such judicial authorization is very different from the power to force someone to undergo decontamination, and the two issues must be dealt with separately under the *Health Protection and Promotion Act.*

It must again be emphasized that the solution to public health emergencies is voluntary cooperation, not coercive legal powers. Coercive legal powers will never work in the face of significant non-cooperation. The key lies not in the coercive powers required for ultimate backup, but in the initial work of emergency responders in informing people what is medically required and why it is in their own best interest to cooperate. No matter how strongly the statutory authority for such a power is worded, it will be impossible to enforce without the support and cooperation of those directly affected.

The Commission recommends that the power to detain for decontamination and to decontaminate by court order in the absence of consent, should come under the day to day powers of the *Health Protection and Promotion Act* and not be limited to a power available only during a declared provincial emergency. A problem that requires decontamination may emerge suddenly before an emergency is even contemplated, as in an unexpected terrorist attack by weaponized smallpox or anthrax.

In addition to amending the *Health Protection and Promotion Act* to allow for the power to detain temporarily for the purposes of identification and the power to detain for decontamination, the provisions, which now authorize detention for the purposes of examination, treatment, isolation or to prevent the spread of disease, need to be strengthened.

As noted above, s. 35 allows a court to order detention of a person who refuses to submit to an examination, treatment, isolation or to conduct themselves in such a way so as to avoid the spread of disease. The power can only be exercised by court order. What do you do with a virulently infectious person in an area thronged with people on a Saturday evening, who refuses to go for treatment? A medical officer of health, under s. 22 of the *Health Protection and Promotion Act,* could order the person to submit to an examination, treatment and to isolate themselves. But if the infectious person thumbs his nose at the authorities, they can do nothing under the present law absent a court order under s. 35 of the Act. There is no power to detain the person while an application is being made to court. The person can continue to infect the throng or can wander away and disappear and infect others. Under the present law nothing can be done to stop them. This is unsatisfactory.

The medical officer of health requires the authority to order a person temporarily detained, for the purposes of isolation or to prevent the spread of disease, pending a court hearing under s. 35. The detention would be temporary, requiring that the person be brought before a justice within 24 hours, to ensure their detention is justified and that they are given their due process rights. The order would be available only where a person refuses to comply with the s. 22 order. The power to detain, like the other powers to detain discussed above, must be backed up by the power to arrest in the case of non-cooperation and the power to invoke police assistance. The power should be valid whether made in writing or orally by a medical officer of health.

It is important to note that this temporary power of detention would not include any power in relation to treatment. It is a key component of our law that no person shall be treated without their consent, without a court order. To obtain such a court order there must first be a hearing, which meets all the rules of natural justice. That fundamental protection must apply and should not be diluted in any manner.

While the power to detain a person, however temporarily, amounts to a violation of their liberty, such a power may be found to be reasonable and justified where it is necessary to protect the public from a virulent disease. It must come with strong protection, to make it as temporary as possible, pending a court order. It should only be available to a medical officer of health and the Chief Medical Officer of Health.

All of these recommended powers involve the ultimate assistance of the police in those cases where there is non-cooperation to the point where police assistance is required. There is no greater source of potential enforcement problems than the boundary line between two separate agencies who are required suddenly and without warning to cooperate smoothly in the face of an unexpected crisis. It is therefore of the utmost importance that police and public health authorities develop protocols, education packages, and training exercises to ensure smooth and effective cooperation.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order temporarily detained for identification any person who refuses to provide their name, address and telephone contact information when required to do so for the purpose of identifying those who are leaving, or have been in a place of infection. The detained person, unless immediately released, must be brought before a justice as soon as possible and in any event within 24 hours for a court hearing. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of, for the purpose of a**

court hearing, any person suspected of having been exposed to a health hazard, and who refuses to consent to decontamination. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of anyone who there is reason to suspect is infected with an agent of a virulent disease, for the purposes of obtaining a judicial order authorizing the isolation, examination or treatment of the person, pursuant to s. 35 of the *Health Protection and Promotion Act.* The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

Power to Enter A Dwelling-House

Public health officials are of the view that in some cases they require the power to enter a dwelling-house. In their view, this power is important to enforce orders under the Act.

Most public health officials agree that the *Health Protection and Promotion Act* should be amended to include a power of entry when enforcing a judicial order to apprehend made after a court application under s. 35 of the Act. As one medical officer of health described the problem to the Commission:

> Public health agencies face the difficulty of trying to enforce an Order under HPPA s. 35, authorizing a police service to "locate, apprehend and deliver" a person with an infectious disease to a hospital named in the Order. The specific difficulty is the lack of any provision in the HPPA authorizing the police to enter into a private dwelling for the purpose of apprehending and delivering the subject of the Order to a hospital. We have become aware that, in the absence of any such authorizing provision, the police take the view that they do not have any powers of entry. In a situation where a person is the subject of a s. 35 Order to locate, apprehend and deliver him or her to a hospital for treatment in accordance with the terms of the Order, the lack of police powers of entry means that in order for the apprehension of the subject individual to occur, inordinate resources must be spent by the public health agency or the police on surveillance, etc. to identify an opportunity when the subject of the Order can be apprehended outside of whatever private dwelling they may be located in. As well, there may be delay and concomitant opportunity for the subject of the Order to evade apprehension. The resulting opportunity to spread the infectious disease sought to be treated pursuant to the s. 35 Order is obvious.

This is not a remote hypothetical situation. Public health officials reported to the Commission the example of a woman in a major urban center in Ontario who was infected with tuberculosis (TB). Public health officials issued a s. 22 order against the woman, requiring that she isolate herself and seek treatment. She refused to comply. They obtained a court order under s. 35 of the *Health Protection and Promotion Act*, authorizing that she be apprehended, isolated and treated. Because the order did not authorize entry to her home, public health officials had to sit outside her home waiting for her to leave. In the meantime, she continued to reside with other family members in the house, while she was infectious. Public health officials were unable to constantly maintain surveillance on the home. She managed to leave her home, travel to the airport and leave the country, exposing countless other people on her journey. She was later apprehended while attempting to re-enter Canada.

Had the court been able to authorize as part of the s. 35 order entry to her home to apprehend her and ensure she was isolated and treated, the risk she posed to countless people in the community and abroad could have been prevented.

The references to rights of entry are contained in Part V of the *Health Protection and Promotion Act*. Section 41 of the Act authorizes public health inspectors, inspectors, a medical officer of health or a person acting under the direction of a medical officer of health, to enter any premises, other than a private dwelling, to enforce the Act, exercise a power or carry out a duty under the Act, or carry out a direction given under the Act.[160] Subsection 43(1)

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[160] Subsection 41(1) provides:

> Rights of entry and powers of inspection
>
> Interpretation persons
>
> The persons referred to in subsections (3) to (5) and (8), (10) and (11) are the following:
>
> 1. An inspector appointed by the Minister.
>
> 2. A medical officer of health.
>
> 3. A public health inspector.
>
> 4. A person acting under a direction given by a medical officer of health.
>
> Interpretation purposes
>
> (2) The purposes mentioned in ss. (3) to (5) and (11) are the following:
>
> 1. The purpose of this Act.
>
> 2. The enforcement of any section of this Act or the regulations.
>
> 3. The exercise of a power or the carrying out of a duty under this Act or the regulations.
>
> 4. The carrying out of a direction given under this Act.
>
> Entry

authorizes issuance of a warrant permitting entry to a premises for the purpose of enforcing the Act or Regulations, and for exercising a power or carrying out a duty or direction under the Act. Subsection 43(1) provides:

> Where a justice of the peace is satisfied on evidence upon oath,
>
> (a) that there is reasonable and probable grounds for believing that it is necessary,
>
> (i) to enter and have access to, through and over any premises,
>
> (ii) to make examinations, investigations, tests and inquiries, and
>
> (iii) to make, take and remove samples, copies or extracts related to an examination, investigation, test or inquiry,
>
> or to do any of such things, for the purpose of this Act, the enforcement of any section of this Act or the regulations, the exercise of a power or the carrying out of a duty under this Act or the regulations or the carrying out of a direction given under this Act; and
>
> (b) that an inspector appointed by the Minister, a medical officer of health, a public health inspector or a person acting under a direction given by a medical officer of health,
>
> (i) has been denied entry to the premises,
>
> (ii) has been instructed to leave the premises,
>
> (iii) has been obstructed, or
>
> (iv) has been refused production of any thing or any plant or animal related to an examination, investigation, test or inquiry,
>
> by the occupier of the premises,
>
> the justice of the peace may issue a warrant in the form prescribed by the regulations authorizing an inspector appointed by the Minister, a medical officer of health, a public health inspector and any person who is acting under a direction given by a medical officer of health, or any of them, to act as mentioned in clause (a) in respect of the premises

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(3) A person mentioned in s. (1) may enter and have access to, through and over any premises for a purpose mentioned in s. (2).

Private Residence

(7) Subsection (3) is not authority to enter a private residence without the consent of the occupier.

> specified in the warrant, by force if necessary, together with such police officer or officers as they call upon to assist them.

While the power contained in s. 43 authorizes entry into "any premises," it confers no explicit authority to enter a private dwelling to apprehend a person. The fact that s. 43(1) does not expressly prohibit such entry into a private dwelling is hardly relevant because the law requires explicit language to authorize such entry into a dwelling and the courts will not read that power into a statute unless it is expressly conferred. The activities identified in paragraph (a) refer to testing things, removing samples, and accessing premises, not to entry for the purposes of apprehending a person and to doing "any of such things." If the drafters intended this section to contain the power to enter a private dwelling to apprehend a person, one of the most serious of all enforcement actions, one would expect they would have clearly said so. The absence of any reference to apprehending a person strongly suggests that this section is not intended to authorize such an action.

It is questionable whether the authority to enter a private dwelling and apprehend a person is provided in the *Provincial Offences Act.*[161] Section 158(1) allows the issuance of a warrant authorizing entry to any place, but the language of that section speaks to entry for the purposes of searching for and seizing evidence, not the apprehension of an individual.

These sections, s. 43 of the *Health Protection and Promotion Act*, and s. 158 of the *Provincial Offences Act*, do not clearly authorize entry to a private dwelling and apprehension of an individual who is the subject of an order under s. 35 of the Act. The Court should have the power in appropriate circumstances to authorize entry into a home for the purpose of enforcing a court order to take a person into custody. Given the scarcity of resources available to public health and the other critical demands on the time and resources of police services, neither should be expected to establish around the clock surveillance for an

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[161] R.S.O. 1990, c. P-33. Section 158(1) provides:

> Search Warrant
>
> Where a justice is satisfied by information upon oath that there is reasonable ground to believe that there is in any building, receptacle or place,
>
> > (a) anything upon or in respect of which an offence has been or is suspected to have been committed; or
> >
> > (b) anything that there is reasonable ground to believe will afford evidence as to the commission of an offence,
>
> the justice may at any time issue a warrant in the prescribed form under his or her hand authorizing a police officer or person named therein to search such building, receptacle or place for any such thing, and to seize and carry it before the justice issuing the warrant or another justice to be dealt with by him or her according to law.

Section 100 of the *Health Protection and Promotion Act* provides that anyone who does not comply with an order under the Act is guilty of an offence:

> 100. Any person who fails to obey an order made under this Act is guilty of an offence

indeterminable amount of time until the person who is the subject of the order decides to leave their home. Under the present system, however, that is the only method available to prevent the person from leaving home and spreading a virulent disease throughout the community. The power to enter a private dwelling to execute an order under s. 35 of the Act is an important one. It must be clearly authorized in the *Health Protection and Promotion Act* so as to avoid legal debate and confusion regarding whether or not the authority exists.

For example, Dr. Henry explained to the Justice Policy Committee how this power would enhance the ability to enforce isolation orders:

> Who has the authority to detain somebody who's not actually sick but might be a hazard, but we don't know? Who has the authority if we have a section 35 order on somebody who is sick with tuberculosis but they are in their private home? Nobody has the right, right now, to go in and actually get them. We can't do that. Should we have that? I don't know. I think those are authorities that need to be looked at very closely in the legislation.[162]

A local medical officer of health proposed a solution as follows:

> In my respectful submission, one way of dealing with this would be to provide police powers of entry into private dwellings in order to exercise the direction from a Court to locate, apprehend and deliver the subject of a s. 35 Order to a hospital. Such powers of entry would not be unique or unusual. For example, s. 36 (5) of the *Children's Law Reform Act* gives the police the power to enter and search any place for the purpose of locating and apprehending a child who has been wrongfully withheld from a parent, and who is the subject of an Order under s. 36. When a CLRA s. 36 Order is made, there are certain guidelines that must be followed by the police with respect to the times when such a power of entry may be exercised.
>
> Certainly, police powers of entry must be authorized by law and exercised judiciously when circumstances require. Certainly, we highly value the concept of a person's home being their castle. However, equally certainly, there are circumstances when public health concerns with respect to mandating treatment and preventing the spread of infectious diseases mitigate in favour of allowing police to enter into a private dwelling to carry out an Order under s. 35. Carefully crafted amendments to the *Health Protection and Promotion Act* could address these competing interests, and might be critical in dealing with any future outbreaks similar to the one we experienced during the SARS crisis.

The need for this amendment is clear.

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[162] Justice Policy Committee, Public Hearings, August 18, 2004, p. 152.

However, others have submitted to the Commission that there is a need for a broader power of entry, without a warrant or prior judicial authorization, in cases where the medical officer of health has reasonable and probable grounds to believe there is a risk to health due to a health hazard or an infectious disease.

The Ministry of Health in its submission to the Commission proposed the following amendment:

> Authorizing medical officers of health to enter any premises, including a private residence, without a warrant, where the medical officer has reasonable and probable grounds to believe there is a risk to health due to a health hazard or an infectious disease.[163]

Dr. Basrur, the Chief Medical Officer of Health for Ontario, in her testimony before the Justice Policy Committee, explained the rationale for such a power:

> Finally, extraordinary powers may be needed for a local medical officer of health to enter any premises, including a private residence, without a warrant – and I take a breath when I say this – where he or she has reasonable grounds to believe that a risk to health exists due to a health hazard or an infectious disease, if there is a declared emergency under the Emergency Management Act. By way of a small example that gives you the kind of dilemma we face, on a day-to-day basis we have authority to regulate food premises. Yet you can have a catering operation that operates out of someone's private residence, and the duty to inspect, the right of access to enter those premises where it is also a private home, is not crystal clear. That may just be the way it is in a free and democratic society on a day-to-day basis, but if you're in an emergency situation, you probably want some additional authority to be able to kick in.[164]

Reasonable though this may seem to those with the difficult task of protecting the public against infectious disease, the power to enter a dwelling house without judicial authorization is an extraordinary power. The distinction between the power to enter a home without a warrant and the power to enter a business or factory without a warrant is vital not only in a legal sense but also as a matter of public policy. Mr. Mike Colle, the acting Chair of the Justice Policy Committee, asked the following questions about the right of entry under the *Environmental Protection Act*:

> Could they enter a home without a warrant? This is what came up yesterday. Dr. Young felt that they had no power to enter private property. They would be charged with trespassing. Yet the Ministry of the Environment has already solved the problem.

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[163] Letter to Mr. Doug Hunt, Q.C., Commission Counsel, from Mr. Phil Hassen, deputy Minister of Health and Long-Term Care, August 4, 2004. See Appendix H to this Report.

[164] Justice Policy Committee, Public Hearings, August 18, 2003, p. 143.

> . . .
>
> The question I want clarified is that this is essentially private property, whether it be a plant, a place of business or a residence. I think this is very crucial for our committee, given Dr. Young's presentation yesterday. He felt one of the encumbrances to dealing with an emergency was that they really had no power to trespass or to enter a person's home.[165]

The Supreme Court of Canada in *R. v. Feeney* ruled that warrantless entry of a dwelling house to make an arrest, offended the *Charter of Rights and Freedoms* even in a case where the police were in fresh pursuit of a murder suspect.[166] The courts have recognized however that in cases of "exigent circumstances" a police officer may enter a home without a warrant. Although courts have been reluctant to define "exigent circumstances" in general terms, obvious cases include emergency response to a 911 call suggesting that someone's life is in danger, or entry to a burning house to save an occupant.

After *Feeney*, Parliament amended the *Criminal Code* to provide tightly defined powers to enter a dwelling house without a warrant when there are reasonable grounds to suspect it is necessary to prevent imminent bodily harm or death to any person.[167]

Although rare, cases may arise where a corresponding power is necessary to enter a residence to secure the immediate detention of someone who poses a grave immediate risk to the health of others if not detained. However, in the view of the Commission, the power should be a limited one. It is one thing to have these powers to enforce an isolation order under s. 35, where the goal is preventing the spread of infectious disease, but it is quite another to have these powers in respect of other public health activities, such as food safety.

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[165] *Ibid*, August 4, 2003, p. 43.

[166] *R. v. Feeney*, [1997] 2 S.C.R. 13.

[167] Section 529.3 provides:

> (1) Without limiting or restricting any power a peace officer may have to enter a dwelling-house under this or any other Act or law, the peace officer may enter the dwelling-house for the purpose of arresting or apprehending, a person, without a warrant referred to in section 529 or 529.1 authorizing the entry, if the peace officer has reasonable grounds to believe that the person is present in the dwelling-house, and the conditions for obtaining a warrant under section 529.1 exist but by reason of exigent circumstances it would be impracticable to obtain a warrant.
>
> (2) For the purposes of subsection (1), exigent circumstances include circumstances in which the peace officer
>
>> (a) has reasonable grounds to suspect that entry into the dwelling-house is necessary to prevent imminent bodily harm or death to any person; or
>>
>> (b) has reasonable grounds to believe that evidence relating to the commission of an indictable offence is present in the dwelling-house and that entry into the dwelling-house is necessary to prevent the imminent loss or imminent destruction of the evidence.

The Commission therefore recommends that the *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.

But the power to enter without a warrant must be limited by conditions analogous to those in the *Criminal Code Feeney* amendments and further limited by a court hearing as soon as possible and in any event within 24 hours.

The Commission therefore recommends that the *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a private dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.**
- **The *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling-house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.**

Conclusion

As noted at the beginning of this chapter, the *Health Protection and Promotion Act*, which provides the legal machinery for our defence against infectious disease, needs to be stronger. It is the daily powers in the *Health Protection and Promotion Act*, powers of investigation, mitigation, and risk management that prevent public health emergencies from developing. It is these daily powers that require strengthening.

Public health officials, to protect us from disease and to prevent small problems from growing into emergencies, require access to health risk information and the authority, resources, and expertise to investigate, intervene, and enforce.

The powers and safeguards recommended above are necessary to achieve these ends.

Recommendations

The Commission therefore recommends that:

- **The role and authority of public health officials in relation to hospitals be clearly defined in the *Health Protection and Promotion Act* in accordance with the following principles:**
  - **The requirement that each public health unit have a presence in hospital infection control committees should be entrenched in the Act; and**
  - **The authority of the local medical officers of health and the Chief Medical Officer of Health in relation to institutional infectious disease surveillance and control should be enacted to include, without being limited to, the power to monitor, advise, investigate, require investigation by the hospital or an independent investigator, and intervene where necessary.**
- **The Ministry of Health and Long-Term Care, in consultation with the Provincial Infectious Diseases Advisory Committee, and the wider health care and public health communities, define a broad reporting trigger that would require reporting to public health where there is an infection control problem or an unexplained illness or cluster of illness.**
- **Whether or not a workable trigger can be defined for compulsory reporting, a provision be added to the *Health Protection and Promotion Act*, to provide that a physician, infection control practitioner or hospital administrator may voluntarily report to public health officials the presence of any threat to the health of the population.**
- **The *Health Protection and Promotion Act* be amended to include powers similar to those set out in Quebec's *Public Health Act*, to allow for early intervention and investigation of situations, not limited to reportable or communicable diseases, that may pose a threat to the health of the public.**
- **The *Health Protection and Promotion Act* be amended to clarify and regularize in a transparent system authorized by law, the**

respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding how a particular case should be classified.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to issue directives to hospitals, medical clinics, long-term care facilities, and all other health care providers, private or public, in respect of precautions and procedures necessary to protect the public's health. All directives should be issued under the signature of the Chief Medical Officer of Health alone.

- The Ministry of Health and Long-Term Care appoint a working group of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by the directives knows how they work, what they mean and how they should be applied.

- The Ministry of Health and Long-Term Care, in consultation with the affected health care communities, develop feedback machinery driven by health care workers in the field, to ensure the directives are clear and manageable from a practical point of view in the field.

- The *Health Protection and Promotion Act* and the directives provide explicitly that they in no way diminish the procedures and precautions required by the circumstances that prevail in any particular institution, that they represent the floor, not the ceiling, of medical precaution, and do not relieve any institution of the obligation to take further precautions where medically indicated.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order temporarily detained for identification any person who refuses to provide their name, address and telephone contact information when required to do so for the purpose of identifying those who are leaving, or have been in a place of infection. The detained person unless immediately released, must be brought before a justice as soon as possible and in any event within 24 hours for a court hearing. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of, for the purpose of a court hearing, any person suspected of having been exposed to a health hazard, and who refuses to consent to decontamination. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of anyone who there is reason to suspect is infected with an agent of a virulent disease, for the purposes of obtaining a judicial order authorizing the isolation, examination or treatment of the person, pursuant to s. 35 of the *Health Protection and Promotion Act.* The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- The *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a private dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.

- The *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling-house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.

5. Reporting Infectious Disease

It is a cornerstone of our protection against infectious disease that doctors and hospitals and public institutions are legally required to disclose to public health authorities every case of reportable disease. Without knowledge of the prevalence and incidence of TB or SARS, who has it, who may have it, where did they get it, how, from whom, who else may be at risk, public health officials are powerless in the face of infectious outbreaks. Unless cases are reported to public health, it cannot investigate or even be aware of impending danger. Without adequate information the medical officer of health cannot protect the public.

The legal obligation to report infectious disease is a foundation of every system of public health legislation. The legal obligation is necessary not only to encourage reporting but also to ensure that the confidentiality laws, designed to protect patient privacy, do not unintentionally undermine the ability of public health authorities to fight the spread of infectious disease. To express the machinery of obligation in point form:

- The *Health Protection and Promotion Act* requires under certain conditions the reporting: to the medical officer of health;

- by hospitals, other institutions,[168] doctors and other health care professionals and practitioners[169] including nurses, chiropractors, dentists, pharmacists, optometrists, and drugless practitioners;

- of the fact that a patient has or may have a disease specified in overlapping definitions as communicable, reportable, or virulent.

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[168] Subsection 21(1) provides:

> In this Part, "institution" means,
>
> > (a) "charitable institution" within the meaning of the *Charitable Institutions Act*, (b) premises approved under subsection 9 (1) of Part I (Flexible Services) of the *Child and Family Services Act*, (c) "children's residence" within the meaning of Part IX (Licensing) of the *Child and Family Services Act*, (d) "day nursery" within the meaning of the *Day Nurseries Act*, (e) "facility" within the meaning of the *Developmental Services Act*, (f) Repealed: 2001, c. 13, s. 17. (g) "home for special care" within the meaning of the *Homes for Special Care Act*, (h) "home" within the meaning of the *Homes for the Aged and Rest Homes Act*, (i) "psychiatric facility" within the meaning of the *Mental Health Act*, (j) "approved home" and "institution" within the meaning of the *Mental Hospitals Act*, (k) "correctional institution" within the meaning of the *Ministry of Correctional Services Act*, (l) "detention facility" within the meaning of section 16.1 of the *Police Services Act*, (m) "nursing home" within the meaning of the *Nursing Homes Act*, (n) "private hospital" within the meaning of the *Private Hospitals Act*, (o) place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada),
> >
> > and includes any other place of a similar nature; ("établissement")

[169] Subsection 25(2) defines practitioner as a member of the College of Chiropractors of Ontario, a member of the Royal College of Dental Surgeons of Ontario, a member of the College of Nurses of Ontario, a member of the Ontario College of Pharmacists, a member of the College of Optometrists of Ontario or a person registered as a drugless practitioner under the *Drugless Practitioners Act*.

The conditions of reporting outlined below are unnecessarily complex and in places apparently illogical. Structural elements that require amendment include:

- the inconsistent obligations on doctors and others to report some cases and not others, depending on whether the patient is in hospital or an out-patient or someone who walked into a doctor's office;
- the limited categories of who must report;
- the absence of a broad power to allow the Chief Medical Officer of Health to obtain information, including personal health information, from any person, institution or government department, where the information is necessary to prevent the spread of an infectious disease;
- the lack of precision in the necessary timeliness of the reporting; and
- the different levels of information required to be reported, depending on the identity of the disclosing party.

SARS demonstrated the importance of notifying public health of the risk of an infectious disease in a health care setting or any other part of the community. Vital information about infectious disease typically comes to light only when a patient seeks medical treatment from a health care worker, whether it be a doctor, nurse, clinic, hospital or indeed from any health care practitioner. This confidential patient information can only be shared with public health officials if there is a legal duty or authority to do so. Without such legal duty and authority every doctor and nurse and health care practitioner runs the risk of violating privacy legislation and public health officials will lack the power to compel the disclosure by a reluctant health information custodian. Infectious disease will not pause for a legal debate on whether the disease should be reported to public health. During an infectious outbreak it is critical that the reporting structure set out in the *Health Protection and Promotion Act* be clear and unassailable so that health professionals understand and properly discharge their reporting obligations under the Act, confident in their legal authority to do so. Only then will public health officials be armed with the information needed to protect the public.

Current Reporting Requirements

The *Health Protection and Promotion Act* puts reporting obligations on physicians, practitioners,[170] hospital administrators, superintendents of institutions, school principals, and laboratory operators. Pursuant to the Act, these individuals must report a case to public health in the case of a patient who has or may have a reportable or communicable disease.

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[170] Subsection 25(2) defines practitioner as a member of the College of Chiropractors of Ontario, a member of the Royal College of Dental Surgeons of Ontario, a member of the College of Nurses of Ontario, a member of the Ontario College of Pharmacists, a member of the College of Optometrists of Ontario or a person registered as a drugless practitioner under the *Drugless Practitioners Act.*

Reporting obligations under the *HPPA* are triggered by the requirement that a disease be either reportable or communicable. The lists of reportable and communicable diseases are set out in the Regulations to the *Health Protection and Promotion Act.* Regulation 558/91 specifies the communicable diseases, while Regulation 559/91 specifies the reportable diseases. This designation is vital. It is only where a person has or may have a reportable or communicable disease that the obligations are triggered under the Act.

Sections 25 through 30 of the *Health Protection and Promotion Act* impose reporting duties on specific groups of individuals such as doctors, nurses, hospital administrators, superintendents of institutions, school principals, and laboratory operators. They are as follows:

> s. 25(1) A physician or a practitioner as defined in subsection (2) who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided.
>
> s. 26 A physician who, while providing professional services to a person, forms the opinion that the person is or may be infected with an agent of a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided.
>
> s.27 (1) The administrator of a hospital shall report to the medical officer of health of the health unit in which the hospital is located if an entry in the records of the hospital in respect of a patient in or an out-patient of the hospital states that the patient or out-patient has or may have a reportable disease or is or may be infected with an agent of the communicable disease.
>
> s.27(2) The superintendent of an institution shall report to the medical officer of health of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease.
>
> s.27(3) The administrator or the superintendent shall report to the medical officer of health as soon as possible after the entry is made in the records of the hospital or institution, as the case may be.

> s. 28 The principal of a school who is of the opinion that a pupil in the school has or may have a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the school is located.
>
> s. 29(1) The operator of a laboratory shall report to the medical officer of health of the health unit in which the laboratory is located each case of a positive laboratory finding in respect of a reportable disease, as soon as possible after the making of the finding.
>
> s. 29(2) A report under this section shall state the laboratory findings and shall be made within the time prescribed by the regulations.

In addition to these provisions, s. 30 imposes a reporting condition on a physician who signs a medical certificate of death where the cause of death or a contributing cause of death was a reportable disease.[171]

It is important to note the distinction between the reporting requirements in s. 25 and s. 26, discussed in detail below.

The overriding goal of the reporting provisions should be a clear statement of the reporting obligations of any party who could potentially have information about the presence or suspected presence of a communicable disease. Unfortunately, the current provisions contain some clear gaps addressed below, which have impeded the ability of public health officials to obtain reports regarding diseases.

In Hospital or Out of Hospital

Section 25 requires physicians and practitioners caring for patients who are not in-patients or out-patients at a hospital to report reportable diseases. Section 26 requires physicians, regardless of the status of the patient, to report communicable diseases. It is unclear why the legislation distinguishes between the reporting of reportable diseases and the reporting of communicable diseases. Perhaps physicians and other practitioners treating patients in a hospital or who are out-patients of a hospital are precluded from reporting obligations in s. 25 because of a belief that the reporting will occur under s. 27, via the hospital administrator. However, both physicians/practitioners and hospital administrators have reporting duties where the disease is communicable, and it is unclear why reportable diseases would be treated differently, particularly since not all reportable diseases are communicable.[172] If there are two categories of diseases and both are sufficiently serious threats to public health that they require reporting from a hospital administrator and from physicians and practitioners working with persons who are not in-patients or out-patients of a hospital, it is unclear why the reporting requirements are not the same regardless of the patient's location.

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[171] Section 30 provides:

> A physician who signs a medical certificate of death in the form prescribed by the regulations under the Vital Statistics Act where the cause of death was a reportable disease or a reportable disease was the contributing cause of death shall, as soon as possible after signing the certificate, report thereon to the medical officer of health of the health unit in which the death occurred.

[172] As noted above, all communicable diseases are reportable but not all reportable diseases are communicable.

Whatever the logic of the distinction between reportable and communicable diseases in ss. 25 and 26, public health officials interviewed by the Commission expressed a common position that leaving reporting in any case to a hospital administrator is insufficient. Many public health officials reported to the Commission that they frequently did not receive reports from hospital administrators. In fairness, the hospital administrator can only report what they are aware of, so absent a functioning internal system requiring immediate reporting to them, they may not be aware that a case exists. Whether they are aware of a case or not, as one public health official stated, "it is the hospital doctors and the health care workers that we need access to", not hospital administrators. It is insufficient in the case of hospitals to leave reporting to the hospital administrator. The hospital administrator is unlikely to be working when the infectious patient enters the emergency room in the middle of the night. Public health officials need to connect with the emergency room physician and staff to obtain information necessary to begin their important work of ensuring the infectious disease remains contained and does not threaten the public's health.

As noted below, the scope of information that a physician must provide under s. 25 is far greater than that which a hospital administrator must provide under s. 27. Consequently, a physician in a family clinic may be required under the *Health Protection and Promotion Act* to provide far greater information on a reportable disease than a hospital administrator when the patient is an in-patient or out-patient of a hospital. This distinction makes little sense, as the importance of notifying public health of the existence or suspicion of a reportable disease does not turn on the location of the patient. Therefore, s. 27 does not compensate for the exclusion of hospital physicians in s. 25. This gap in the reporting requirements frustrates public health officials who require information to perform their duties. One public health expert described the problem, using tuberculosis (TB) cases as an example:

> It's been an ongoing frustrating problem. We're not getting information about the most recent chest X-rays, we're not getting information about medication that patients may be on, or when they come from the hospital out into the community. We're just not getting the information that our public health docs are telling me that we need. Some hospitals are better than others. But there just seems to be a brick wall there. And we're being faced with, well, we don't have to provide anything other than name and address, date of birth, sex and date of onset of symptoms, because that's all we're required to report under s. 1(1), but 1(2) is, for example, currently not directed at the hospital administrator. And that's one of the reasons why we wanted to take out the words "who is a patient or an in-patient" at the hospital, because it's the physicians in the hospital that have all the information that aren't reporting it to us.

It would be far more effective simply to combine ss. 25 and 26 and to require all physicians, regardless of the status of the patient, to report a disease that is either reportable or communicable. This way, a physician would be legally required to report and, as a backup, the hospital administrator would also have a legal duty to report pursuant to s. 27. Duplicate reporting obligations raise potential concerns around multiple reporting and around who is primarily responsible to report. Public health officials advise, however, that over-reporting would be preferable to the current trend of under-reporting. This problem could be easily addressed by ensuring an effective internal compliance system within each hospital or institution. As one public health expert stated:

> Multiple reporting doesn't happen. We get under-reporting. Now a hospital administrator has to report but they don't do it. I think it should be incumbent on the hospital to have a reporting policy. For example, if a nurse identifies a disease she can say the most responsible physician should report it, or is it the infection control people – but they need to have an internal way of doing that. Right now what mostly happens is everyone thinks everyone else does it and it is not done.

Such an internal compliance system would not only allow physicians and health care workers to ensure compliance with reporting obligations, but would serve to identify those cases where the obligations have not been fulfilled. Hospitals are busy places and physicians have enormous responsibilities in providing patient care. Clear reporting obligations, even if they result in multiplication of duties, can only serve to ensure that cases do not slip through the cracks.

A group of highly qualified experts involved in the SARS response advised the Commission:

> Presently, section 25 of the HPPA speaks to the reporting requirements for physicians; however, this only refers to those services provided outside of hospitals. This leaves a gap in reporting of patients who are seen as either out-patients of the hospital or who are admitted to a hospital by physicians. Presently, the HPPA requires the administrator of the hospital to report cases of reportable diseases for out-patients and in-patients of a hospital. It is suggested that compelling hospital-based physicians to report consistent with requirements applicable to out of hospital will build redundancy and will assure reporting of such cases.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to repeal, in the duty of a physician to report to the medical officer of health, the distinction between hospital patients and non-hospital patients. This may be achieved by deleting from s. 25(1) the words "who is not a patient in or an out-patient of a hospital."**

- **The Ministry of Health and Long-Term Care require each hospital, long-term care facility, nursing home, home for the aged,**

community care access centre, private medical or health services clinic, and any health care institution, to establish an internal system to ensure compliance with the reporting obligations set out in the *Health Protection and Promotion Act.*

Expanding the Categories of those who must Report

As noted above, the *Health Protection and Promotion Act* imposes reporting obligations on specified groups of persons such as doctors, nurses, hospital administrators, superintendents of institutions, school principals, and laboratory operators. A gap in the system emerges where a caregiver such as a midwife has information about a reportable or communicable disease and the caregiver does not fall into one of the categories of people listed in ss. 25 through 30.

Section 25 requires that a physician or a practitioner who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease, shall make a report to the medical officer of health of the health unit in which the professional services are provided. Subsection 25(2) defines "practitioner". It provides:

> (2) In subsection (1), "practitioner" means,
>
> (a) a member of the College of Chiropractors of Ontario,
>
> (b) a member of the Royal College of Dental Surgeons of Ontario,
>
> (c) a member of the College of Nurses of Ontario,
>
> (d) a member of the Ontario College of Pharmacists,
>
> (e) a member of the College of Optometrists of Ontario, or
>
> (f) a person registered as a drugless practitioner under the *Drugless Practitioners Act.* 1998, c. 18, Sched. G, s. 55 (3).

Pursuant to s. 27(2), a superintendent of an institution must report to the medical officer of health of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease. "Institution" is defined in s. 21(1) as:

> "institution" means,
>
> (a) "charitable institution" within the meaning of the *Charitable Institutions Act*,
>
> (b) premises approved under subsection 9 (1) of Part I (Flexible Services) of the *Child and Family Services Act*,

(c) "children's residence" within the meaning of Part IX (Licensing) of the *Child and Family Services Act*,

(d) "day nursery" within the meaning of the *Day Nurseries Act*,

(e) "facility" within the meaning of the *Developmental Services Act*,

(f) Repealed: 2001, c. 13, s. 17.

(g) "home for special care" within the meaning of the *Homes for Special Care Act*,

(h) "home" within the meaning of the *Homes for the Aged and Rest Homes Act*,

(i) "psychiatric facility" within the meaning of the *Mental Health Act*,

(j) "approved home" and "institution" within the meaning of the *Mental Hospitals Act*,

(k) "correctional institution" within the meaning of the *Ministry of Correctional Services Act*,

(l) "detention facility" within the meaning of section 16.1 of the *Police Services Act*,

(m) "nursing home" within the meaning of the *Nursing Homes Act*,

(n) "private hospital" within the meaning of the *Private Hospitals Act*,

(o) place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada),

and includes any other place of a similar nature; ("établissement")

"superintendent" means the person who has for the time being the direct and actual superintendence and charge of an institution ("chef d'établissement").

But a health care provider may have information regarding a communicable disease and may not be a member of one of the professional bodies set out in s. 25(2) nor a superintendent of an institution as defined in the Act. In such a case, there would be no reporting obligation, and the provision of personal health information to public health authorities to prevent the spread of infectious disease may require intensive legal review of privacy legislation before a health care provider could be confident of their ability to disclose constitute a violation of privacy legislation. For example, recently, the case of a midwife caring for a pregnant woman with Hepatitis B came to the attention of public health officials through a mandatory report from a laboratory. Public health officials had the name of the midwife and the mother as a result of receiving the lab slip, reporting the positive Hepatitis B test. However, the lab slip did not give public health officials enough information about the patient to allow them to conduct their investigation to ensure that the newborn received the necessary vaccinations. In the normal course, public health would have contacted the treating physician or health care provider to obtain the additional information. Time was of the essence as public health officials had a relatively small window during which they could vaccinate the newborn to prevent it from contracting Hepatitis from its mother. The midwife, although wanting to cooperate with public health officials, felt that she could not disclose the required information as it was confidential health information and she had no duty under the *Health Protection and Promotion Act* to report. A midwife is not a "practitioner" as defined in the Act.

An easy solution lies in simply adding all potential custodians of health information to the list of "practitioners" under the *Health Protection and Promotion Act.* Some have suggested that the solution lies in adding to the definition of practitioners the list of professionals set out in the *Regulated Health Professionals Act.*[173] Others have suggested that this list would be overly broad, capturing people who would not have such information. As one person remarked:

> … it might capture people where it would be of limited utility to have them be included, such as massage therapists or dieticians. One wonders how far you want the net to expand and there are some " non-traditional" professions included in the *Regulated Health Professions Act.*

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[173] S.O. 1991, c. 18, Sched. 1 – SELF GOVERNING HEALTH PROFESSIONS

Health Profession Acts	Health Profession
Audiology and Speech-Language Pathology Act, 1991	Audiology and Speech-Language Pathology
Chiropody Act, 1991	Chiropody
Chiropractic Act, 1991	Chiropractic
Dental Hygiene Act, 1991	Dental Hygiene
Dental Technology Act, 1991	Dental Technology
Dentistry Act, 1991	Dentistry
Denturism Act, 1991	Denturism
Dietetics Act, 1991	Dietetics
Massage Therapy Act, 1991	Massage Therapy
Medical Laboratory Technology Act, 1991	Medical Laboratory Technology
Medical Radiation Technology Act, 1991	Medical Radiation Technology
Medicine Act, 1991	Medicine
Midwifery Act, 1991	Midwifery
Nursing Act, 1991	Nursing
Occupational Therapy Act, 1991	Occupational Therapy
Opticianry Act, 1991	Opticianry
Optometry Act, 1991	Optometry
Pharmacy Act, 1991	Pharmacy
Physiotherapy Act, 1991	Physiotherapy
Psychology Act, 1991	Psychology
Respiratory Therapy Act, 1991	Respiratory Therapy

On the other hand, it is better to cast the net too widely than too narrowly, and to include health care providers, whether traditional or non-traditional, who have information vital to public health. When the Act was drafted in the early 1980's, and through all its amendments since then, clearly no one contemplated the scenario where a midwife might hold critical information. The danger in trying to predict every possible category of person or institution is that one that does not seem relevant today suddenly becomes relevant in the future.

Another suggested solution has been to redefine practitioner in the *Health Protection and Promotion Act* to match the definition in the *Personal Health Information Protection Act*. In s. 2 of the *Personal Health Information Protection Act*, "health care practitioner" is defined as follows:

> "health care practitioner" means,
>
> (a) a person who is a member within the meaning of the Regulated Health Professionals Act, 1991 and who provides health care,
>
> (b) a person who is registered as a drugless practitioner under the Drugless Practitioners Act and who provides health care,
>
> (c) a person who is a member of the Ontario College of Social Workers and Social Service Workers and who provides health care, or
>
> (d) any other person whose primary function is to provide health care for payment; ("praticien de la santé")

This definition is quite broad. It includes not only everyone who is a member within the meaning of the *Regulated Health Professionals Act*, but also has a broad catch-all provision that includes any person whose primary function is to provide health care for payment. It is important that the definition of "practitioner" in the *Health Protection and Promotion Act*, be amended to conform with that in the *Personal Health Information Protection Act*.

Even beyond the definition of "practitioner" and "institution," the list of custodians who are identified in the *Personal Health Information Protection Act* as being potential custodians of personal health information, is far broader than those with reporting obligations under the *Health Protection and Promotion Act*. In s. 3(1) of the *Personal Health Information Protection Act*, "health information custodian" is defined as follows:

> In this Act, "health information custodian," subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:
>
> 1. A health care practitioner or a person who operates a group practice of health care practitioners.

2. A service provider within the meaning of the *Long-Term Care Act, 1994* who provides a community service to which that Act applies.

3. A community care access corporation within the meaning of the *Community Care Access Corporations Act, 2001*.

4. A person who operates one of the following facilities, programmes or services:

   i. A hospital within the meaning of the *Public Hospitals Act*, a private hospital within the meaning of the *Private Hospitals Act*, a psychiatric facility within the meaning of the *Mental Health Act*, an institution within the meaning of the *Mental Hospitals Act* or an independent health facility within the meaning of the *Independent Health Facilities Act*.

   ii. An approved charitable home for the aged within the meaning of the *Charitable Institutions Act*, a placement coordinator described in subsection 9.6 (2) of that *Act*, a home or joint home within the meaning of the *Homes for the Aged and Rest Homes Act*, a placement coordinator described in subsection 18 (2) of that Act, a nursing home within the meaning of the *Nursing Homes Act*, a placement coordinator described in subsection 20.1 (2) of that Act or a care home within the meaning of the *Tenant Protection Act*, 1997.

   iii. A pharmacy within the meaning of Part VI of the *Drug and Pharmacies Regulation Act*.

   iv. A laboratory or a specimen collection centre as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*.

   v. An ambulance service within the meaning of the *Ambulance Act*.

   vi. A home for special care within the meaning of the *Homes for Special Care Act*.

   vii. A centre, program or service for community health or mental health whose primary purpose is the provision of health care.

5. An evaluator within the meaning of the *Health Care Consent Act, 1996* or an assessor within the meaning of the *Substitute Decisions Act, 1992*.

6. A medical officer of health or a board of health within the meaning of the *Health Protection and Promotion Act*.

7. The Minister, together with the Ministry of the Minister if the context so requires.

> 8. Any other person prescribed as a health information custodian if the person has custody or control of personal health information as a result of or in connection with performing prescribed powers, duties or work or any prescribed class of such persons.

The definition of "health information custodian" in the *Personal Health Information Protection Act* is far broader than that contained in the *Health Protection and Promotion Act*. It follows that a broad spectrum of health care providers have strong duties to protect the patient privacy with no corresponding duty to override that privacy where necessary to tell public health authorities and so prevent the spread of deadly infection. For example, ambulance services do not have reporting obligations under the *Health Protection and Promotion Act*. Service providers within the meaning of the *Long Term Care Act*, are not included in the definition of either "practitioner" or "institution" in the *Health Protection and Promotion Act*. While s. 29(1) requires that the operator of a laboratory report, it does not include a laboratory specimen collection centre. Community Care Access Corporations are not included in the reporting sections of the *Health Protection and Promotion Act*. Nor are pharmacies included in the *Health Protection and Promotion Act*. The drafters of the *Personal Health Information Protection Act* obviously contemplated that these groups and individuals might have personal health information and it necessarily follows that they might have health information in relation to a communicable disease. It follows that they should have clear reporting obligations.

The list of "practitioners" and "institutions" as defined in the *Health Protection and Promotion Act* should be kept up-to-date and should be easily amended to ensure that all those who may receive personal health information about a patient infected with a communicable disease have reporting obligations. There should also be consistency between the *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* to avoid the current situation where some have a clear duty not to disclose without the concurrent duty to disclose in the case of a communicable disease.

Recommendations

The Commission therefore recommends that:

- **The definition of "practitioner" in the *Health Protection and Promotion Act* be amended to coincide with that set out in the *Personal Health Information Protection Act*.**

- **The list of "institutions" as defined in s. 21(1) of the *Health Protection and Promotion Act*, be amended to coincide with that set out in the *Personal Health Information Protection Act*.**

- **The *Health Protection and Promotion Act* be amended to ensure consistency between those who are defined as "health information custodians" under the *Personal Health Information Protection Act* and those who have reporting obligations under the *Health Protection and Promotion Act*.**

- **The *Health Protection and Promotion Act* be amended to authorize the Minister of Health and Long-Term Care to amend the definition of "practitioner" or "institution" by regulation.**

Broad Powers to Obtain Information

It is a band-aid solution to amend the *Health Protection and Promotion Act* each time a new health care provider or a gap in the existing legislation is identified. It may be impossible to predict every potential custodian of information relevant to public health officials in communicable disease prevention and control. As the case of the midwife illustrated above, an investigation into a potential infectious disease will very likely require speed. This cannot be achieved if the only solution lies in amending the *Health Protection and Promotion Act* every time a person with important health information turns out to be exempt from the Act. Medical officers of health must have the power to ask for personal health information from any person or institution, where the information is required to prevent the spread of infectious disease or any other risk to the public's health. Their ability to protect the public from health threats, in particular infectious diseases, should not turn on the ability of legislative drafters to foresee each and every possible source of information.

This problem became apparent early into SARS, when it became necessary to amend the *Hospital Management Regulation*[174] under the *Public Hospitals Act* to require hospitals to provide medical information to public health officials in respect of SARS. Section 23.2[175] of the *Hospital Management Regulation* was added to provide:

> 23.2 (1) A hospital shall provide information from records of personal health information to the following persons for the purposes of the diagnosis of persons who may have contracted SARS and the investigation, prevention, treatment and containment of SARS:
>
> 1. The Chief Medical Officer of Health within the meaning of the *Health Protection and Promotion Act*.
>
> 2. A medical officer of health within the meaning of the *Health Protection and Promotion Act*.
>
> 3. A physician designated by the Chief Medical Officer of Health.
>
> (2) In subsection (1), "SARS" means severe acute respiratory syndrome.

It demonstrates a fundamental weakness in the structure of the *Health Protection and Promotion Act* reporting system that this amendment was necessary in the middle of SARS. Public health legislation must be robust enough to require the flow of necessary information from hospitals to public health officials at all times. It should not be necessary to amend the reporting requirements in the middle of an outbreak of some new disease.

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[174] R.R.O. 1990, Regulation 965.

[175] O. Reg. 201/03, s. 1., made under the *Public Hospitals Act*.

The problem of collecting information about risks that are not defined as either a health hazard or as a reportable disease arose after SARS, as individual health units were required to collect information and attempt to be informed and proactive in respect of febrile respiratory illnesses within hospitals. One public health lawyer described the problem for the Commission:

> I think it's important for us to know these things are happening, as well. For example, if there's some sort of strange trend going on at a hospital, everyone has this high fever, we never find out about it, because it's not a reportable disease, it's not a communicable disease, and then we find out about it when there's a SARS outbreak. There's nothing really for us to be sharing information so that we know there might be something that can happen here and can we do something to prevent it. Can we implement some infection control protocols? Can we be prepared for it? There's nothing really allows us to foreshadow that something like this is going to occur. And I think the Ministry is asking us to collect information about febrile respiratory illness and severe respiratory illness, and all the health units are asking well, what is our authority to require the hospitals to give us that information? And the hospitals are calling us saying, we're not giving it to you, because there's nothing in the statute that requires us to report that. And the Ministry I think was trying to get something that would allow us to forecast. Well if there's some weird thing, a lot of people with a fever, certain other symptoms, maybe there's something that we need to investigate, we need to have discussions about and see whether it's happening in other places. And there's nothing really that allows us to do that.

One hospital in particular took the position that there was not only an absence of legal authority to report cases of febrile respiratory illness to public health officials, but that to do so would be a contravention of privacy legislation. As noted later in this chapter, respiratory infection outbreaks were recently added to Regulation 569, as requiring reporting to public health officials to address this issue.

The fundamental weakness in the *Health Protection and Promotion Act* is that it does not enable public health authorities to acquire the information from hospitals and other health care institutions that is needed to protect the public against infectious disease. This fundamental weakness is not cured by a narrow spot amendment restricted to SARS in an obscure hospital regulation outside the framework of the *Health Protection and Promotion Act*. The amendment applies only to SARS and not to any other infectious or communicable or reportable or virulent disease. Nor does it apply to any new disease that might at first, like SARS, not even have a name.

It is essential to ensure that public health officials, in the event of any infectious disease outbreak, have access to whatever information they require to protect the public. Tinkering is not enough. The fundamental weakness in reporting requirements, demonstrated by the SARS spot amendment to the *Public Hospitals Act*, should be remedied by a *Health Protection and Promotion Act* amendment to provide that hospitals must provide to public health the information it needs to fight infectious outbreaks.

Quebec has addressed this problem in its *Public Health Act*, through a power available to the public health director. Under s. 96 of the Act the public health director may conduct an epidemiological investigation in any situation where he or she believes on reasonable grounds that the health of the population is or could be threatened and, in particular, where the director receives a report of an intoxication, infection or disease as required by the Act and regulations. Section 100 sets out the powers of the public health director in the course of an epidemiological investigation. One of these powers, set out in s. 100(8), provides the public health director the power to obtain information relevant to an epidemiological investigation from any source. It states:

> [The Public Health Director may] order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential.

The Quebec legislation strikes a balance between the need to identify cases and access private health information quickly, and the need to ensure privacy is respected and that the power is not over utilized.

If a similar provision were added to the *Health Protection and Promotion Act*, the local medical officer of health would still have the power recommended below to request further details on reported cases from parties with reporting obligations under the Act. A general power for the Chief Medical Officer of Health to request and obtain information, similar to that set out in Quebec's *Public Health Act*, would fill a gap in cases where the person with vital information about a disease, or any other health risk, did not happen to be listed as someone with a legal duty to report. The power must be broad, to allow for access to information where a disease or health risk is previously unknown or unidentified.

Required information may not be limited to details about specific cases. It may also include the provision of specimens. The Ministry of Health and Long-Term Care in its written submission to the Commission,[176] stressed the need for an amendment to the *Health Protection and Promotion Act* to provide the authority for the Chief Medical Officer of Health to:

> … order the collection, analysis, and retention of any laboratory specimen from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test

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[176] Letter to Mr. Douglas Hunt, Q.C., Commission Counsel, from Mr. Phil Hassen, Deputy Minister of Health and Long-Term Care, August 4, 2004. See Appendix H to this Report.

> analyses from anyone, and to disclose the results of test analyses as the Chief Medical Officer of Health considers appropriate.

Dr. Basrur, in her appearance before the Justice Policy Committee, explained this proposed power:

> Authorizing the Chief MOH to order the collection, analysis and retention of any lab specimen from any person, plant or anything that he or she specifies: That sounds pretty open-ended. You might want that if you come across an incident that you've never anticipated in your life.
>
> Authorizing the Chief MOH to acquire previously collected specimens: My neighbour to my left gave blood when she was expecting a baby. That blood is in storage and, in an emergency, I can take that and use it for some other purpose. You might want to think about what kinds of safeguards would be necessary to protect the individual and, frankly, to protect the official and the government so that they're doing the right thing and not more than is absolutely necessary.[177]

The Commission accepts this proposal with a few qualifications. First, it should not include the power to take a bodily sample or specimen from a person without their consent or, absent consent, without court approval. The power must only apply to specimens already taken. The protection of one's bodily integrity is a fundamental part of our law[178] that must be protected from unreasonable state intrusion. Second, the collection must be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen must be used only for this express purpose. For example, a specimen taken for the purposes of investigating whether a person is infected with a virulent disease should not then be available to the state for any other purpose.[179] Third, this power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.

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[177] Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.

[178] In *R. v. Stillman* (1997), 133 C.C.C. (3rd) the Supreme Court of Canada stated that seizures that infringe upon a person's bodily integrity, may constitute the "ultimate affront to human dignity" (at p. 341). The Court said:

> It has often been clearly and forcefully expressed that state interference with a person's bodily integrity is a breach of a person's privacy and an affront to human dignity (at p. 342).

Recently, in *R. v. Tessling*, [2004] S.C.J. No. 63, the Supreme Court of Canada said:

> Privacy of the person perhaps has the strongest claim to constitutional shelter because it protects bodily integrity, and in particular the right not to have our bodies touched or explored to disclose objects or matters we wish to conceal. [para. 21]

[179] The Supreme Court of Canada has ruled that seizure of a blood sample that is authorized by law for the purposes of the provincial *Coroner's Act* cannot be used for the purpose of a *Criminal Code* prosecution for impaired driving. See *Colarusso v. The Queen* (1994), 87 C.C.C. (3d) 193. [1994] 1 S.C.R. 20.

The above proposed amendments would give Ontario's public health authorities the ability to acquire information about cases of infectious disease necessary to protect the public. By making the power available only to the Chief Medical Officer of Health, it would ensure that the Chief Medical Officer of Health is aware and kept informed of new and unidentified risks throughout the province.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to include a provision similar to the provisions in Quebec's *Public Health Act*, by which the Quebec public health director may order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential.**

- **This power should be broadly defined, to enable the Chief Medical Officer of Health to require any person, organization, institution, government department or other entity, to provide information, including personal health information, to the Chief Medical Officer of Health, for the purposes of investigating and preventing the spread of infectious disease.[180]**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to order the collection, analysis and retention of any laboratory specimen from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analysis from anyone, and to disclose the results of test analysis as the Chief Medical Officer of Health considers appropriate for the purpose of investigating and preventing the spread of infectious disease.[181] This power, however, should be subject to the following restrictions:**
    - **It should not include the power to take a bodily sample or specimen directly from a person without their consent or,**

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[180] As noted above, this is not drafting language. The use of the term "infectious disease" is intended to include but not be restricted to diseases already designated as communicable, reportable or virulent under the *Health Protection and Promotion Act*. The provision should be defined broadly enough to cover bioterrorism risks. It should not, however, extend to every health risk, such as obesity or other lifestyle problems.

[181] *Ibid.*

absent consent, without court order. The power should only apply to specimens already taken;

- **The collection should be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen should be used only for this express purpose; and**

- **The power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.**

Timing

Neither the *Health Protection and Promotion Act* nor the Regulations specify how soon a report must be made.[182] The reporting sections set out in ss. 25 through 30 of the Act simply state that the report must be made "as soon as possible" after the opinion is formed, which is not defined. Is that within an hour, a day, or a few days? What if the physician or the administrator is busy or overworked? Does it mean as soon as is convenient for them? Many medical officers of health have raised this issue and have noted the need for immediate notification to enable them to respond to a problem before it spreads out of control. As one public health expert stated:

> We need to set a timeframe within which the reports have to be made. This is a chronic problem for public health where the legislation says you have to report but it doesn't say within what timeframe. This doesn't help public health in terms of their ability to do work. It leaves us with little enforcement alternatives as physicians who are not reporting cannot be prosecuted for breaching legislation because there is no time frame.

Given the importance of timely public health intervention in the case of a communicable or infectious disease, it is important to specify that the reporting must be immediate in those cases where time is of the essence. But it may not be necessary for every reportable disease to be reported immediately. It may be necessary to require immediate reporting only for those diseases where immediate notification and intervention is necessary for public health protection.

For example, in Quebec, the Minister's Regulation under the *Public Health Act*[183] requires that for certain diseases[184] the report must be made to both the national public health director and the public health director in the territory, immediately, by telephone and also in writing within 24 hours. For other diseases, however, the report must be made to public health, in writing, within 24 hours.[185]

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[182] The Ministry of Health and Long-Term Care distributes an information sheet that contains a list of diseases which they request be reported immediately. This list however does not carry with it the force of law, but merely acts as a guideline for reporting institutions.

[183] R.S.Q., c. S-2.2, ss. 47, 48, 79, 81 to 83 and s. 136, paras. 6, 8 and 9.

[184] Section 1 provides that in the case of Anthrax, Botulism, Cholera, Plague, Smallpox, Viral haemorrhagic fever, Yellow fever, a report must be made "immediately, by telephone, by any physician and any chief executive officer of a laboratory or of a department of medical biology to the national public health director

Recent amendments to the reporting regulations set out in Regulation 569, amended to O. Reg. 1/05, identify the need for immediate reporting from the local level to the provincial level. Subsection 6(1) previously stated:

> Where a medical officer of health receives a report made under section 25, 26, 27 or 28, subsection 29(2) or section 30 of the Act, he or she shall forward a copy to the Public Health Branch of the Ministry.

It has been amended to state:

> Where a medical officer of health receives a report made under section 25, 26, 27 or 28, subsection 29(2) or section 30 of the Act, he or she shall immediately forward a copy to the Public Health Branch of the Ministry in a secure manner.

It is easy to understand why the Ministry would want to ensure immediate reporting from the local level to the provincial level. However, unless the local level also benefits from a similar legal requirement that reports from the field be made immediately to them, the effectiveness of the entire reporting regime will be undermined. There is little benefit to the Ministry of receiving an "immediate" report from the local level when the local level has received news of an infectious disease days or weeks after the fact.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to require that in the case of specific diseases, designated by regulation, information be reported "immediately" by telephone to the local medical officer of health, and that such report be followed up in writing within 24 hours.**

- **The *Health Protection and Promotion Act* be amended to require that as in the case of those diseases not designated for immediate reporting, a written report must be provided to the local medical officer of health within 24 hours.**

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and the public health director in the territory" and that "A written report must also be transmitted to those authorities within 48 hours by the person making the report."

[185] See the *Minister's Public Health Regulations*, ss. 2 through 5.

Content of the Report

The *Health Protection and Promotion Act*, and its accompanying regulations, must be clear not only as to who must report and when, but must also be clear as to what information must be reported. It is frustrating for a medical officer of health to request information that he or she knows is relevant and necessary to control the spread of an infectious disease or to investigate a possible outbreak of an infectious disease, only to be told that he or she is not legally entitled to the information. It is similarly frustrating for the physician or practitioner who wants to assist public health but does not want to violate privacy laws. The law should be so clear that the physician and the practitioner need no longer grapple with these legal puzzles in the midst of a busy practice and other important demands on their time. The Regulation, which sets out the type of information that must be provided in a report, was recently amended. While the changes go a long way to improving the inadequacy of the previous version of the Regulation, there are still improvements that need to be made for the sake of clarity for public health officials and for those with reporting obligations.

The amendments are a positive step towards the goal of arming medical officers of health with greater information to allow them to prevent the spread of an infectious disease. With a little clarification and a little more strength the new Regulation will go a long way to address the concerns of local medical officers of health in respect of their difficulties in obtaining necessary details about reported cases from health care providers.

The *Health Protection and Promotion Act* does not specify what information must be reported to the medical officer of health. It simply provides that a report must be made. Regulation 569 specifies the type of information that must be provided to the medical officer of health. A number of problems with the Regulation have recently been addressed in Regulation 1/05. Two specific problems were the limited list of information required to be included in a report under the Act, and the limited class of people who were required to provide additional information as requested by the medical officer of health.

Regulation 569, both previous and current, state that the following information is required when making a report under the Act:

> 1(1) A report required under s. 25, 26 or 27 of the Act shall, with respect to the person to whom the report relates, contain the following information:
>
> 1. Name and address in full.
> 2. Date of birth in full.
> 3. Sex.
> 4. Date of onset of symptoms.
>
> 1(2) A report required under section 28 of the Act shall, with respect to the pupil to whom the report relates, contain the following information:
>
> 1. Name and address in full.
> 2. Date of birth in full.

3. Sex.
4. Name and address in full of the school that the pupil attends.

1(3) A report made under subsection 29(1) of the Act [by a laboratory operator] shall, with respect to the person to whom the finding was made, be made within twenty-four hours of the making of the finding and shall contain the following information:

1. Name and address in full.
2. Date of birth in full.
3. Sex.
4. Date when the specimen was taken that yielded the positive finding.
5. Name and address in full of the physician or dentist attending the person.

1(4) A report made under subsection 30 of the Act [by a physician who signs a death certificate] shall, with respect to the deceased, contain the following information:

1. Name and address in full.
2. Date of birth in full.
3. Date of death in full.
4 Name and address in full of the physicians who attended the deceased.

Section 5 of the Regulation specifies in what cases additional information must be reported, together with what additional information must be provided with the report of disease. Prior to the recent amendment, there were seven diseases listed in s. 5,[186] requiring that additional, specified information be provided when reporting. The amendments to Regulation 569, effected by O. Reg 1/05, have significantly expanded both the list of diseases for which additional information must be reported, and the type of information that must be reported. Under the new amendments, some 66 diseases now require additional information beyond the basic information set out in s. 1(1) of Regulation 569. The amendments cover all diseases listed in the three categories of disease specified by regulation: communicable, reportable and virulent. Although at first blush Regulation 569 seems to require the provision of very limited information; name, sex, date of birth and date of onset, the result of the amendments to s. 5 of the Regulation is that virtually every disease listed under the regulations, whether it is communicable, reportable or virulent, now requires the provision of additional information as specified in the amendment sections. The information required by the amendment is detailed and broad. In some cases it includes such things as travel history, lab findings, immigration status, contacts identified, contacts traced, history of exposure and the potential for community transmission.

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[186] Syphilis, Gonorrhea, AID, Lassa Fever, Marburg virus disease, Ebola virus disease and Plague.

This amendment brings into force an important change in the scope of information required to be reported. Under the new amendments, those with reporting obligations under the Act are no longer simply required to provide the most basic patient information. The amendments require that significant information about the condition, treatment and history of a patient be reported to the medical officer of health. One expert group described the importance of broadening the reporting requirements under the Act as follows:

> Involved health units during the SARS outbreak encountered difficulties in acquiring diagnostic imaging, laboratory results and clinical status updates on suspect or probable cases of SARS who were hospitalized. It appeared that some hospitals interpreted the *Health Protection and Promotion Act* too narrowly, resulting in their restricting access of the health units to this clinical information feeling that this information was not required to be reported unless dealing with a confirmed "reportable disease". We recommend that appropriate sections be added to the reporting regulations to provide the medical officer of health with the authority to acquire additional information as required to allow control of the disease or an outbreak. This may include information about contacts as well as information about diagnostic and laboratory tests and results of negative laboratory tests, treatment and prognosis of cases from hospitals, clinics and schools. The rationale for this recommendation is to facilitate local Medical Officers of Health and the Chief Medical Officer of Health in investigating and managing an outbreak that often requires more than just minimal demographic information.

While the amendments are a helpful start to rectifying the difficulties experienced by public health in obtaining additional information in relation to reportable diseases, they appear to have been drafted with little input from local medical officers of health in the field or their counsel, who assist them in interpreting the Act and its regulations. A number of inconsistencies and ambiguities in the language used in the Regulation should be addressed in order to strengthen the Regulation.[187]

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[187] A few examples of ambiguity and inconsistency are as follows: In relation to reporting of contacts, s. 5(1)(xii) requires that the number of contacts be reported yet says nothing about reporting the name of the contacts. This problem likewise exists in ss. 5(5), 5(6), 5(9), 5(10), 5(11), 5(12) and 5(17). All require the reporting of numerical information about contacts, such as the number identified, the number traced, the number quarantined, and the number tested, but say nothing about reporting their names. Subsection 5(5)(xxii) refers to the "number of contacts of the person who have been traced," whereas the other sections that require reporting on contacts refer to the "number of contacts traced." Subsection 5(7)(iv), however, refers to "the contacts who have been traced." Although a minor point, there should be consistency in language in the Regulation. Similarly, the sections that require contact information, identified above, require reporting of "the number of contacts tested and number of contacts treated," yet s. 5(5)(xxiii) refers to "number of contacts tested and treated, if applicable." Again, although a minor discrepancy, it reflects a lack of overall clarity in some aspects of the drafting of the regulation. Another apparent inconsistency can be found in respect of the requirement to report the use of an ambulance. Subsection 5(4)(ix) requires that the reporting party state if an ambulance was used and date of use. This information may be important to both identify ambulance personnel involved in transporting the patient to determine their exposure and risk and where a disease is either airborne or spread by droplets to ensure that the ambulance and the machinery inside have been properly cleaned and is not itself a vector for contagion. This was critical during SARS as some ambulance personnel did contract

The Regulation requires that a number of pieces of information be reported, of which the reporting party may not have knowledge. The Regulation fails to make it clear that the reporting parties need only report what is known to them, and that they are not obliged to conduct their own independent investigation to obtain all of the information set out in the regulations. As noted below, the names and personal information of contacts, where known, should clearly be reported, but it should not be the job of the physician or hospital to track down contacts of which they have no knowledge. To take another example, the reporting party should not be required to investigate the patient's immigration status, if the patient or a relative are unable to communicate it.

It seems curious that the reporting party is required to identify the health unit responsible for reporting contacts, a fact more appropriately within the knowledge of the public health authorities. It is open to question whether the reporting party should be obliged to identify the "case classification," or whether this is a matter for public health authorities to determine in their internal reporting from the local health unit to the province and their external reporting to Health Canada or the World Health Organization. If the "case designation" has to do with reports made by public health after the information is received from the physician, it might be better to separate the reporting obligations of physicians to public health from the reporting obligations that arise within the public health system after the physician makes the report.

As helpful as the amendments are, they do not eliminate the need for the power of the medical officers of health and the Chief Medical Officer of Health to request additional information from any person or institution making a report under the Act, if that information is required in order to respond to that report. SARS taught us many lessons about the wide variety of information required to fight an infectious disease. Things such as travel history, employment status (is the patient a health care worker) and contact information became critically important during SARS. A piece of information that seems irrelevant now may suddenly become relevant in the face of a new disease. A new disease may necessitate the provision of a detail not currently identified in the regulations.

To that end, s. 1(2) of Regulation 569 allows the medical officer of health to request additional information from the reporting party. Prior to the amendments in Regulation 01/05, this power to request additional information was limited to those making a report

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SARS while attending to and transporting infectious patients. Yet this reporting requirement is only required in relation to Lassa Fever, Hemorrhagic fevers, including Ebola virus disease, Marburg virus disease and Hemorrhagic fevers from other viral causes and Plague. While these are clearly highly infectious and deadly diseases, identifying those cases transported by ambulance could also be important for cases such as SARS, yet it is not a listed piece of information in relation to that disease. Another potential problem can be found in s. 5(12)(vi), which sets out the information that must be reported in relation to respiratory infection outbreaks in institutions. One of the reporting requirements is to report the date of the outbreak and the outbreak number. This is followed by the requirement the date the outbreak was declared over. The unfortunate use of the past tense and the wording of that subsection leads the reader to wonder if it may be permissible to report an outbreak after the outbreak is over rather than when it first comes to the attention of the health care provider or institution. Perhaps the reporting hospital should be required to report the date the outbreak "is" declared over or the ongoing status of the outbreak in the hospital. To require them to report the date the outbreak was declared over suggests that the reporting is going to occur after that fact.

under s. 25 and s. 26, failing to include hospital administrators who have obligations to report under s. 27. The new amendments address this, adding reports made under s. 27 to s. 1(2).

The Commission recommends that the power of the medical officer of health to request additional information from a party with reporting obligations under the Act should apply to all those individuals and institutions required to report. Thus, those parties with obligations to report under s. 28 (school principals), s. 29 (labs), and s. 30 (a physician who signs a medical certificate of death where the cause of death or a contributing cause of death was a reportable disease) may also be legally required to provide any additional information requested by the medical officer of health in relation to the report.

The Commission further recommends that the power currently contained in s. 1(2), of the Regulation, which enables the medical officer of health to request additional information from any party reporting under the Act, be entrenched in the Act itself, protected from any subsequent amendment without legislative debate and openness as to the reasons for the amendment. Rather than being limited to the current specific categories of people and institutions required to report, the power should be directed at any person or institution who makes or is required to make a report under the Act.

Recommendation

The Commission therefore recommends that:

- **Subsection 1(2) of Regulation 569 be expanded to apply to any person who makes a report under the *Health Protection and Promotion Act.* Thus any person who gives information in accordance with a duty under the *Health Protection and Promotion Act*, shall, upon the request of the medical officer of health, give to the medical officer of health such additional information respecting the reportable disease or communicable disease as the medical officer of health considers necessary.**
- **This portion of Regulation 569 (s. 1(2), additional information) be moved to the Act itself, to form an integral part of the reporting obligations set out in the Act and to ensure that the power is protected, absent legislative debate, from subsequent amendment.**
- **Amendments to the *Health Protection and Promotion Act* and Regulations be preceded by consultation with the public health community who have to apply them in the field.**

Reporting Contacts of Cases

Another gap in the legislation that became apparent during SARS is that the *Health Protection and Promotion Act* only requires that information be given in respect of a patient. Nothing in the Act requires a physician or hospital to provide information about contacts of the patient.

This information turned out to be crucial during SARS, as the management of SARS required the identification and isolation of contacts to prevent the spread of the disease. Information about the identification of contacts became particularly critical in the context of health care workers exposed to SARS patients, as they often became a vector for transmission requiring early identification and isolation to stop the spread of SARS.

The reporting of contacts is important for diseases beyond SARS. As one public health expert stated:

> I think there are a number of diseases where it's really important to identify contacts. We need to keep them away from people … for example, people we don't know about have been around people with TB and they then develop it themselves and then pass on to other people.

A submission to the Commission from a group of experts, who were all closely involved in the SARS response, recommended that the reporting sections of the *Health Protection and Promotion Act* be amended to support the work of health units in tracing the contacts of patients with infectious diseases:

> The current HPPA does not give specific reference to contacts of infectious cases. Release of information on the cases as well as contacts is essential for infectious disease control. This was a major obstacle during the management of the SARS outbreak. We believe that the requirement to report contacts referred to specifically in the legislation will allow practitioners to provide this information to their medical officer of health.

The amendments to Regulation 569, effected in Regulation 01/05, address this issue. Contacts initially identified or later traced are included in most of the lists specifying additional information that must be reported to the medical officer of health. In particular, it is included in the case of SARS, TB, influenza and febrile respiratory illness. This means that those who have reporting obligations under the Act are now required to provide contact information.

Standardizing Reporting

The amendments to Regulation 569 impose significant additional responsibilities, in respect of the type and amount of information that must be provided, on those with reporting obligations under the Act. While this is a positive step for public health, it must be matched with the recognition that health care institutions and facilities are busy places and health care professionals have many demands on their time. An emergency room physician does not, for example, have the time or luxury to sit and spend hours completing reports while ill patients wait to be treated.

Some have complained that there was a lack of uniform reporting requirements during SARS. Different public health units at different times wanted different information transmitted in different ways. Often a health care facility would provide information to a local health unit, only to be called a few moments later by someone from the provincial

Public Health Division or some other part of the government, requesting the same information. In the first interim report, the Commission noted the impossible burden imposed on front line workers by the repetitive and overwhelming demands for information. Professionals will loathe and avoid reporting if the process is overly time consuming or unclear, or if the obligation it imposes changes depending on the recipient of the report. Public health therefore requires a uniform reporting protocol and standardized reporting formats applicable to all institutions. Hospitals must establish internal reporting policies to ensure reporting. Hospitals, physicians and other health care professionals must work together to develop standardized reporting forms, systems and protocols.

As one health expert noted in respect of the expansion of reporting requirements:

> Reporting mechanisms should not be made too onerous. Report either electronically or through a simple fax and ensure there is someone on receiving end. Part of the problem that public health has been plagued with is under funding. As long as [the reporting system] is something relatively quick and easy, I don't think it will be really bad. It comes down to mechanisms for reporting and lack of standardization, something we suffer from constantly. We are going through it now with pandemic flu. No one wants to say you have to do it this way. It irritates everyone and nothing is fixed. Hospitals report in different ways. Some by Excel, some by fax, most by e-mail. If a fixed method in the way a report gets there, whether by a portal in the net … hit it and say I'm hospital number ABC, without lab confirmation I have two cases of TB – looks like it and walks like it, then public health can do what they want to do from there … If you don't mandate what you want and how you want it you are going to get it 350 ways. If hospital A is collecting temperatures in degrees Fahrenheit and hospital B in Celsius, or they are doing blood pressure different ways, you create scenarios where accidents will happen and mistakes will be made. The data ends up being noncomparable. Reproducibility and comparability - if you can't compare your data you will never be able to use it. It needs to be fixed, whoever does it, whether it is done by the Chief Medical Officer of Health in collaboration with a crew of very important people who know what is going on. Someone needs to say what they want and how they want and when they want it. SARS was perfect example of this.

The expansion of reporting obligations requires clarity around who receives the report, who follows up with the information providers when required, and how the information flows after it reaches the hands of public health. Currently, reporting goes from institutions to local public health to the Public Health Division at the Ministry of Health. During SARS however, some health providers, even though they were already supplying all necessary information to their local public health branch, were called directly by the Public Health Division or by the Minister's staff:

> During SARS we had examples of phone calls from political staff asking for nominal information on those who were ill from the local medical officers of health. The MOH's were just downright irritated by it.

Recommendations

The Commission therefore recommends that:

- **Local public health officials and the Public Health Division, in collaboration and consultation with hospitals, other health care institutions and professional organizations, develop a standardized form and means for reporting under the *Health Protection and Promotion Act.***

- **The standardized reporting include clarity around to whom the report must be made, and to clearly confirm that the chain of transmission goes from the hospital and health care facilities, to the local health units, to the province, so as to avoid multiple requests for information.**

Reporting – Education and Awareness

As noted in the following chapter, Privacy and Disclosure, Ontario has entered a new era of restriction in the sharing of personal health information with the passage of the *Personal Health Information Protection Act.* Much effort has gone into educating health care workers, professionals and administrators about the Act and ensuring that they understand the importance of maintaining the privacy of personal health information. This laudable objective becomes dangerous if it emphasizes overwhelmingly the duty not to disclose without a corresponding emphasis on the duty to disclose to public health officials when required. The duty under the *Health Protection and Promotion Act* to disclose information for the sake of public safety is not discretionary and there should be no mistake about the fact that this duty to disclose overrides any discretionary powers in the *Personal Health Information Protection Act* to withhold information.

Health care professionals and institutions must be educated on the importance of reporting cases immediately to public health, and involving them in discharge decisions of infectious patients. Public health continues to learn about infectious cases long after they have been admitted into hospital and, at times, long after their discharge. Often public health finds out when the patient is readmitted, having spent time in the community while infectious. As one public health official described the problem:

> One of the ongoing issues that public health experiences with TB prevention and control is the lack of reporting on the part of physicians.
>
> In general, the Central Public Health Lab does most of the reporting of new cases. When a specimen is sent to the lab and a positive smear for TB is identified, the lab will send the results to the local health unit. Physicians, although obligated to report TB, rarely report to public health. The majority of the time this lack of reporting is compensated for by the lab. However, about 15 to 20 % of the cases of TB in Toronto are diagnosed clinically, that is there is no lab evidence to support the diagnosis. This may occur because

> the physician does not bother to confirm the diagnosis by sending off specimens, or specimens are sent off and they are of poor quality so the lab cannot confirm the diagnosis, or the TB is diagnosed in an organ or structure such as kidney where it may be difficult to obtain a specimen. It is these cases where the lack of physician reporting can be very serious …
>
> … It is essential that physicians understand the obligation to report and it is essential that they do so in a reasonable period of time to allow public health to assist in the management of the case and to conduct the contact follow-up investigation.

An example of the negative consequences of not reporting can be illustrated through the discussion of a case managed by a local public health unit in the early part of 2004. A man visited a very busy community hospital emergency room with gastrointestinal complaints. After investigation, the patient was started on treatment for TB. This was an appropriate clinical decision as the patient had significant risk factors for TB; he had been in a country where the rate of TB is very high and was intermittently homeless, living in the shelter system. Unfortunately, the physician did not order any confirmatory tests such as a sputum smear, did not report the case to public health, and started the patient on an incorrect treatment regiment. As the physician was feeling uncomfortable with treating TB, he consulted the infectious diseases (ID) service in the hospital and made many attempts to transfer this patient's care to the infectious disease physician. Unfortunately, as this patient was difficult to deal with and presented mental health issues, the ID service was not interested in taking over his care and would only agree to consult. It took more than two weeks for this case to be reported to the local public health unit. By that time, the gastrointestinal physician was overwhelmed with the case as TB was not his area of expertise. He was getting ready to discharge this still infectious patient into the community where he would most likely have ended up back in the shelter system. The public health unit, finally alerted to the situation, interceded, sent in a public health nurse that day to collect a sputum sample to confirm the diagnosis and quickly arranged for this patient's transfer to another hospital able to treat a TB patient. The delay in reporting led to a delay in the ability of the local health unit to initiate a contact follow-up investigation, which ultimately involved two large homeless shelters. The patient had been living in the shelter system for many months while he was symptomatic and infectious with TB. Public health officials described the consequences of this delay in reporting:

> The delay in reporting led to many significant consequences. First, this infectious patient was almost discharged back into the shelter system. More important, the delay in reporting led to a delay in public health being able to initiate a contact follow-up investigation, which ultimately involved two large shelters. This case had been living in the shelter system for many months while he was symptomatic and infectious with TB. A delay in contact follow-up could have meant a delay in finding other infectious cases in the shelter system as a result of exposure to this patient. Fortunately, our contact follow-up investigation did not find other cases of active disease in the involved shelter. However, it is important to note that this population is highly mobile and so the quicker public health can initiate contact follow-up

> the more likely we are to successfully find the identified contacts. In this case, although we didn't find active cases, we also had difficulty locating a significant proportion of the contacts as too much time had lapsed since the exposure and our setting up of contact follow-up clinics. This again was the consequence of a significant reporting delay.

Another example emerged from a TB case in late 2004. The patient had initially entered a busy emergency room suffering from TB. He was briefly treated and released into the community, to reside in the shelter system, without any notification to public health. Shelter workers, upon seeing the ill man, sent him to a different local hospital, as he appeared to them very ill and in desperate need of treatment. Although the patient was admitted to a second hospital where he was treated for TB, public health officials did not become aware of the case for a few days, delaying their initiation of contact tracing.

It is essential that physicians, other health professionals, and health care administrators, understand the obligation to report, and it is essential that they do so quickly to enable public health to do what is required by way of management, investigation and follow-up to protect the public. Physicians and health care providers must understand the important role of public health officials in the management of infectious disease cases. As noted above, it is not only vital to notify public health immediately, but public health must also be kept updated on the status of the patient and discharge plans. Yet public health officials report that this continues to be a frequent problem. The consequences for noncompliance can be severe.

Consider the example of another TB patient admitted to hospital in the early part of 2004. The patient had been diagnosed and treated approximately five years earlier for fully sensitive pulmonary TB. This person unfortunately did not complete the appropriate treatment regimen for TB, was not cured, and as a result the disease "reactivated" in 2004. The patient initially did not take the drugs as prescribed and developed resistance to the most important first line drugs in TB control. When his disease reactivated he was hospitalized for six months and treated for Multi-Drug Resistant [MDR] TB. During hospitalization the patient was compliant with the treatment plan. As MDR TB is the most serious form of TB from a public health point of view due to the resistance to the two most important first line drugs, patients can be hospitalized for up to two years to ensure that the disease has been completely cured. In this case, the hospital planned for discharge six months into this patient's treatment. Local public health officials were not notified of this discharge plan because the hospital was planning to discharge this patient into a region other than that in which the hospital was located. Public health officials described to the Commission the important work that lay ahead for public health officials following a discharge of a patient in this situation:

> It is important to note that when sending an MDR patient home prior to the completion of treatment, the health care provider and public health officials must be completely confident that the individual will comply with isolation at home, take the drugs as directed through complying with directly observed therapy (DOT), and regularly appear for the intensive follow-up at the TB clinic. This follow-up can often be as intensive as every two weeks. The

> reason for these strict discharge conditions is to allow for strict monitoring of the case's level of infectivity. It is to prevent a case of MDR TB from becoming infectious after discharge and inadvertently infecting close contacts and members of the community with the same strain. Preventing transmission of this type of TB is paramount as it is difficult to treat and cure, and it has a very poor prognosis. Transmission of this strain in the community could lead to catastrophic public health consequences as was experienced in the New York City MDR TB outbreak in the 1990's that led to significant morbidity and mortality, transmission across state borders, and cost billions of dollars to contain.

When this patient was discharged, none of the discharge criteria were met. The patient had no fixed address, was highly mobile, often homeless, and had substance abuse issues. The likelihood of compliance in the community was low prior to discharge. The hospital notified the involved health unit approximately two days before discharge. Although the health unit was not in support of the early discharge, the patient was released to a rooming house in an unfamiliar area in June 2004, with the stipulation of complying with directly observed therapy. Not surprisingly, the patient was noncompliant with treatment and within a short period of time became infectious again. The patient was eventually readmitted to the same hospital that had discharged him. In the summer of 2004 he was back in hospital, however, public health officials were not informed until approximately one month later that the patient had been taking the bus every day into another nearby large community during the period of time that he was out in the community. Upon further investigation and interviewing of the patient it became clear that he was circulating within our shelter system and amongst the homeless population while infectious. As a result of this non-reporting, public health officials were unable to identify all those with whom the infectious patient came in contact. The potential for a major outbreak and the cost to public health and the community was very real. As one public health official noted:

> The potential of having an unknown group of contacts exposed to MDR TB in the shelter system who could develop active disease and infect others is daunting, and very similar to what occurred in New York City in the 1990's …
>
> … Due to the resistance pattern of the case, there are currently no drugs that can be effectively used to treat the identified contacts. As a result, this group will have to be followed intensely, at least every 3 months, by the TB clinic to ensure they have not become symptomatic. This will not only stretch the capacity of the TB clinics but it will stretch the capacity of public health. Many of the identified contacts will likely be homeless and highly mobile. Public health will have to ensure that people get to their appointments, which will often mean trying to locate contacts that may have moved to a different shelter or even a different jurisdiction. This type of follow-up will continue for two years. Should any of the identified contacts become symptomatic within these two years or beyond, they will require immediate hospitalization for medical assessment.

> In summary, the consequences of this inappropriate discharge include needless exposure of a serious strain of TB to a vulnerable and still ill-defined population, increased use of resources now and in an ongoing manner by public health and the hospital TB clinic, readmission of this patient with an expanded resistance pattern (over the month while he was taking his drugs erratically he developed resistance to more medications) worsening his prognosis, and the use of key resources at Health Canada to assist in this investigation. The consequences that are less measurable will be the fear and anxiety that is caused when contacts are notified and the anxiety that this will likely cause within the shelter system once public health initiates this investigation in conjunction with Health Canada. This could have been prevented had the hospital been obligated to consult with public health and have the consent of public health before discharging this patient into the community.

It is essential that the Ministry make every effort to educate all those with reporting duties under the Act of their legal obligation to do so. They must do so on an ongoing basis, with a clear emphasis on the important relationship between health care professionals and institutions and public health in protecting the public from infectious diseases. Misunderstanding of Ontario's complex system of privacy laws cannot be permitted to interfere with the duty to report that is required by law to protect the public from infectious disease. Where education fails, enforcement should begin.[188]

Recommendation

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care, Public Health Division, in collaboration with local medical officers of health, health care facilities and professional organizations, engage in broad-based education of reporting requirements under the *Health Protection and Promotion Act* and that such education be maintained on a regular basis.**

Reciprocal Reporting Obligations

All hospitals have a clear interest in ensuring that infectious disease outbreaks do not occur in their facilities. Many hospitals who made submissions to the Commission remarked on the need for a two-way relationship between them and public health. Hospitals want to know when an investigation reveals that their institution is a source of an infectious disease so they can take immediate steps to fix the problem. One hospital put it this way:

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[188] Subsection 100(2) provides:

> Any person who contravenes a requirement of Part IV to make a report in respect of a reportable disease, a communicable disease or a reportable event following the administration of an immunizing agent is guilty of an offence.

> Public health authorities should be mandated, under the *Health Protection and Promotion Act* to provide public hospitals with the confidential health information of persons about whom a report is made, where the investigation of that report gives rise to information that a communicable disease was acquired or may have been acquired at a public hospital. This information is essential to the hospital's ability to determine the extent of a nosocomial outbreak and to take measures to respond to and control the outbreak. The amendments should provide that the information must be communicated as soon as it comes into the possession of the public health authority. Hospitals and physicians are simply not in a position to respond to a potential infectious disease outbreak within the hospital, where information relevant to the outbreak is held outside the hospital.

This recommendation makes great sense.

Section 39(1) of the *Health Protection and Promotion Act* specifically prohibits the medical officer of health from disclosing information received pursuant to a report under the Act. It states:

> 39(1) No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent.

While s. 39(2) provides exceptions to this prohibition, the exceptions do not appear to relate to preventing the spread of an infectious disease.[189] One hospital described the problem to the Commission as follows:

> In particular, there is a need for greater clarity around the hospitals' ability to request health information back from public health with respect to tracing ill

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[189] Subsection 39(1) does not apply,

> (a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;
>
> (b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;
>
> (c) where the disclosure is made for the purposes of public health administration;
>
> (d) in connection with the administration of or a proceeding under this Act, the *Regulated Health Professions Act, 1991*, a health profession Act as defined in subsection 1 (1) of that Act, the *Public Hospitals Act*, the *Health Insurance Act*, the *Canada Health Act* or the *Criminal Code* (Canada), or regulations made thereunder; or
>
> (e) to prevent the reporting of information under section 72 of the *Child and Family Services Act* in respect of a child who is or may be in need of protection.

> staff and transferred patients, who are diagnosed and treated at other institutions, but whose illness is linked to the index hospital. This is essential to the hospital's ability to assess the extent of a nosocomial outbreak internally. Section 39(1) of the *Health Protection and Promotion Act* provides that all information obtained by public health authorities with respect to a person about whom a report has been made will be held in confidence and shall not be disclosed. Section 39(2) of the statute provides certain exceptions allowing disclosure, but it is unclear whether any of these exceptions would permit the disclosure to hospitals required to manage a nosocomial outbreak. It would greatly assist the hospital sector to amend the *Health Protection and Promotion Act* to require public health authorities to report back to a hospital, where public health is in possession of information that suggests a reportable disease may have been acquired through exposure at that hospital. This amendment should not be left to special health emergency legislation, as timely reporting of such information may assist in stemming an outbreak prior to it reaching emergency proportions.

These recommendations are sensible. Hospitals and other health care facilities need information about cases originating or having been treated in their facilities, to enable them properly to assess their risk and respond so as best to protect the safety of other patients and staff. As one medical officer of health also noted, a two-way reporting system between public health and health care institutions can only strengthen the vital relationship between these two partners:

> ... it is important in terms of relationship building in an ongoing way to have that ability to do it so. Where in doubt, it ought to be included to allow us to do that.

The wording of such a section would undoubtedly require that there be some assessment by the medical officer of health that the information was linked to a potential risk to the health of other patients as well as the amount of information that would be necessary to provide to mitigate the risk. As one medical officer of health noted:

> I think there has to be a potential risk to the health of other patients, visitors, and staff. So it implies that there's a risk assessment done by the medical officer of health or staff of the health unit that warrants the provision of this information, both to reduce the clutter of reports coming back that are not actionable by the hospital or the long-term care facility and also to protect information unless it's required.

The ultimate goal is to arm hospitals and other health care institutions with information so they can protect their staff and patients. If information in the hands of public health officials would help hospitals do a better job, public health should give hospitals that information. It has to be a two-way street. Just as public heath requires information from hospitals, so do hospitals and other health care facilities require information from public health. It is completely unhelpful for an institution to learn months after the event that an infectious patient passed through their hospital or that an infectious staff member had been working while ill without the hospital's knowledge. If public health has such information no legal barrier should prevent public health from sharing it with the hospital or any other health care facility. Currently, both s. 39(1) of the *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* may prohibit the sharing of personal health information in such a manner. This should be remedied for the protection of all patients and staff who work in health care institutions.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to require public health authorities to report to a hospital or any other health care facility, including family medical clinics, any information in the hands of public health that suggests a reportable disease may have been acquired through exposure at that site.**

- **Section 39(2) of the *Health Protection and Promotion Act* be amended to include an exception permitting public health officials to provide hospitals and other health care facilities, with the personal health information of persons about whom a report is made, where they are of the opinion that the information may reduce the risk of exposure or transmission to staff, patients or visitors.**

Conclusion

Medical officers of health and the Chief Medical Officer of Health can only protect the public if they are aware of the existence of a threat to the health of the public. In respect of communicable diseases it is critical that health care providers are aware of and vigilant in complying with their reporting obligations under the Act. This requires both education of health care workers and health care institutions as well as a collaborative effort between public health, health care providers and professional bodies to ensure, so much as possible, ease in complying with the reporting obligations under the Act. If the reporting structure or requirements are too onerous they will invite noncompliance. On the other hand, legal duties that are vague or un-enforced will similarly invite noncompliance. It could take only one failure to report the presence or suspected presence of a communicable disease to lead to a serious outbreak in a health care institution or in the community at large.

The Chief Medical Officer of Health requires broad powers to compel information from health information custodians where necessary to protect the public from an infectious disease. The Act and its regulations cannot predict and provide for unknown diseases, such as SARS, which may come upon us suddenly and which require a strong and swift public health response.

There must also be an open exchange of information between health care professionals and public health with a common goal of investigating and preventing the spread of infectious disease.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to repeal, in the duty of a physician to report to the medical officer of health, the distinction between hospital patients and non-hospital patients. This may be achieved by deleting from s. 25(1) the words "who is not a patient in or an out-patient of a hospital."**

- **The Ministry of Health and Long-Term Care require each hospital, long-term care facility, nursing home, home for the aged, community care access centre, private medical or health services clinic, and any health care institution, to establish an internal system to ensure compliance with the reporting obligations set out in the *Health Protection and Promotion Act*.**

- **The definition of "practitioner" in the *Health Protection and Promotion Act* be amended to coincide with that set out in the *Personal Health Information Protection Act*.**

- **The list of "institutions" as defined in s. 21(1) of the *Health Protection and Promotion Act*, be amended to coincide with that set out in the *Personal Health Information Protection Act*.**

- **The *Health Protection and Promotion Act* be amended to ensure consistency between those who are defined as "health information custodians" under the *Personal Health Information Protection Act* and those who have reporting obligations under the *Health Protection and Promotion Act*.**

- **The *Health Protection and Promotion Act* be amended to authorize the Minister of Health and Long-Term Care to amend the definition of "practitioner" or "institution" by regulation.**

- **The *Health Protection and Promotion Act* be amended to include a provision similar to the provisions in Quebec's *Public Health Act*, by which the Quebec public health director may order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential.**

- **This power should be broadly defined, to enable the Chief Medical Officer of Health to require any person, organization, institution, government department or other entity, to provide information, including personal health information, to the Chief Medical Officer of Health, for the purposes of investigating and preventing the spread of infectious disease.**[190]

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to order the collection, analysis and retention of any laboratory specimen from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analysis from anyone, and to disclose the results of test analysis as the Chief Medical Officer of Health considers appropriate for the purpose of investigating and preventing the spread of infectious disease.**[191] **This power, however, should be subject to the following restrictions:**

    - **It should not include the power to take a bodily sample or specimen directly from a person without their consent or, absent consent, without court order. The power should only apply to specimens already taken;**

    - **The collection should be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen should be used only for this express purpose; and**

    - **The power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.**

- **The *Health Protection and Promotion Act* be amended to require that in the case of specific diseases, designated by regulation, information be reported "immediately" by telephone to the local medical officer of health, and that such report be followed up in writing within 24 hours;**

- **The *Health Protection and Promotion Act* be amended to require that as in the case of those diseases not designated for immediate reporting, a written report must be provided to the local medical officer of health within 24 hours.**

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[190] As noted above, this is not drafting language. The use of the term "infectious disease" is intended to include but not be restricted to diseases already designated as communicable, reportable or virulent under the *Health Protection and Promotion Act*. The provision should be defined broadly enough to cover bioterrorism risks. It should not, however, extend to every health risk, such as obesity or other lifestyle problems.

[191] *Ibid.*

- **Subsection 1(2) of Regulation 569 be expanded to apply to any person who makes a report under the *Health Protection and Promotion Act*. Thus any person who gives information in accordance with a duty under the *Health Protection and Promotion Act*, shall, upon the request of the medical officer of health, give to the medical officer of health such additional information respecting the reportable disease or communicable disease, as the medical officer of health considers necessary.**

- **This portion of Regulation 569 (s. 1(2), additional information) be moved to the Act itself, to form an integral part of the reporting obligations set out in the Act and to ensure that the power is protected, absent legislative debate, from subsequent amendment.**

- **Amendments to the *Health Protection and Promotion Act* and Regulations be preceded by consultation with the public health community who have to apply them in the field.**

- **Local public health officials and the Public Health Division, in collaboration and consultation with hospitals, other health care institutions and professional organizations, develop a standardized form and means for reporting under the *Health Protection and Promotion Act*.**

- **The standardized reporting include clarity around to whom the report must be made, and to clearly confirm that the chain of transmission goes from the hospital and health care facilities, to the local health units, to the province, so as to avoid multiple requests for information.**

- **The Ministry of Health and Long-Term Care, Public Health Division, in collaboration with local medical officers of health, health care facilities and professional organizations, engage in broad-based education of reporting requirements under the *Health Protection and Promotion Act* and that such education be maintained on a regular basis.**

- **The *Health Protection and Promotion Act* be amended to require public health authorities to report to a hospital or any other health care facility, including family medical clinics, any information in the hands of public health that suggests a reportable disease may have been acquired through exposure at that site.**

- **Section 39(2) of the *Health Protection and Promotion Act* be amended to include an exception permitting public health officials to provide hospitals and other health care facilities, with the personal health information of persons about whom a report is**

made, where they are of the opinion that the information may reduce the risk of exposure or transmission to staff, patients or visitors.

6. Privacy and Disclosure

To fight infectious disease, public health authorities require timely access to personal health information. The first step to correct the access problems encountered during SARS is to strengthen the reporting and information-sharing provisions of the *Health Protection and Promotion Act* as recommended above.

This, however, is far from enough. The second step is to amend the privacy legislation to make it crystal clear that it was never intended to impede the flow of vital health information mandated by the *Health Protection and Promotion Act.*

Since SARS, a new set of privacy laws have come into force. These complex laws are poorly understood and they create, as a practical matter, serious barriers to the sharing of patient information urgently required by public health authorities.

Even if the *Health Protection and Promotion Act* is amended to expand and clarify reporting obligations and information-sharing powers, those who have the information and the public health officials who need it, will have to navigate a complicated series of privacy laws to see if they are able to disclose information. Consequently, medical officers of health may now expect resistance on two fronts: firstly that the disclosure is not required under the *Health Protection and Promotion Act,* then if they pass that hurdle, that the disclosure is not permissible because it would violate existing privacy legislation.

This is not to criticize the policy behind the new privacy regime. It is not fair to blame privacy policies for failures to report infectious disease as required by law. The problem is that the privacy laws are so complex they are not easily understood even by lawyers. This lack of understanding, coupled with a privacy culture that conditions people to say no to disclosure automatically, must be overcome in relation to the reporting of disease to public health officials.

It is not enough to dismantle the first hurdle of reporting powers and sharing information without addressing also the second hurdle of confusing privacy requirements.

Ontario's Privacy Legislation

In Ontario, Bill 31, *The Personal Health Information Protection Act, 2004* received royal assent on May 20, 2004.[192]

The main provision of *The Personal Health Information Protection Act* authorizing the disclosure of information to public health officials under the *Health Protection and Promotion Act* is s. 39(2)(a) which provides:

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[192] The schedules to the Act did not come into full force until November 1, 2004.

> 39(2) A health information custodian may disclose personal health information about an individual,
>
> > (a) to the Chief Medical Officer of Health or a medical officer of health within the meaning of the Health Protection and Promotion Act if the disclosure is made for a purpose of that Act …

This provision gives health information custodians discretion to disclose information for the purpose of the *Health Protection and Promotion Act.* The broad purposes of the *Health Protection and Promotion Act* include the prevention of the spread of disease.[193]

Although the provision deals with a broad range of disclosure that health information custodians are under no legal obligation to disclose under the *Health Protection and Promotion Act*, it confusingly ignores disclosure that is legally required under specific provisions of the Act.

This provision, by ignoring the legally required disclosure that is at the heart of the *Health Protection and Promotion Act*, does nothing but confuse. It may be understood by lawyers steeped in the intricacies of the *Personal Health Information Protection Act*, to whom the distinction is clear between disclosure "made for a purpose" of the *Health Protection and Promotion Act* and disclosure required by the Act.[194] But it cannot be clear to anyone else.

The provision misleads because it fails to distinguish between the "discretion" to disclose information "for the purpose of" the *Health Protection and Promotion Act* and the duty to disclose information required by the Act. To anyone but a privacy lawyer, it misleadingly suggests that disclosure under the *Health Protection and Promotion Act* is discretionary, not mandatory.

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[193] Section 2 of the *Health Protection and Promotion Act* provides:

> The purpose of this Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario.

[194] They would doubtless point to s. 6(3) of the *Personal Health Information Protection Act* which provides:

> Permissive disclosure
>
> (3) A provision of this Act that permits a health information custodian to disclose personal health information about an individual without the consent of the individual,
>
> > (a) does not require the custodian to disclose it unless required to do so by law;
> >
> > (b) does not relieve the custodian from a legal requirement to disclose the information; and
> >
> > (c) does not prevent the custodian from obtaining the individual's consent for the disclosure.

Whatever the internal legal logic that produced this provision,[195] its dangerous lack of clarity cannot be allowed to stand. It must be made clear to health information custodians that they must disclose all information required by the *Health Protection and Promotion Act* and that they have no discretion to refuse.

The Commission therefore recommends that s. 39 of the *Personal Health Information Protection Act* be amended by the following addition to make it clear that disclosure required by the *Health Protection and Promotion Act* is mandatory, not discretionary:

> A health information custodian shall disclose personal health information about an individual,
>
> > to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act.*

Disclosures that are not authorized by the *Health Protection and Promotion Act* or "for the purpose of the Act" must be authorized by another section in the *Personal Health Information Protection Act.* Authorization for such a disclosure would appear to lie in ss. 43(1)(g) or (h) of the Act, which provides:

> 43(1) A health information custodian may disclose personal health information about an individual …
>
> > (g) subject to the requirements and restrictions, if any, that are prescribed, to a person carrying out an inspection, investigation or similar procedure that is authorized by a warrant or by or under this Act or any other Act of Ontario or an Act of Canada for the purpose of complying with the warrant or for the purpose of facilitating the inspection, investigation or similar procedure;
> >
> > (h) subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada.

Subsection 43(2), the interpretation provision, provides:

> (2) For the purposes of clause (1) (h) and subject to the regulations made under this Act, if an Act, an Act of Canada or a regulation made under any of those Acts specifically provides that information is exempt, under stated circumstances, from a confidentiality or secrecy requirement, that provision shall be deemed to permit the disclosure of the information in the stated circumstances.

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[195] See previous footnote. The only way to do this is to give the mandatory reporting duty in respect of reports required under the *Health Protection and Promotion Act* a more prominent position in relation to s. 39(2) of the *Personal Health Information Protection Act.*

This latter demonstrates the lack of clarity that creates problems in the *Personal Health Information Protection Act*. Although a legal privacy expert may understand it, anyone else would find it hard to grasp. The question is not whether those lawyers intimately familiar with the statute understand what they think it means, but whether the statute is clear to those who have to work with it, and those lawyers who have to advise those who work with it.

In addition to these disclosure provisions, there is a general disclosure power contained in ss. 40(1) of the *Personal Health Information Protection Act:*

> 40(1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

A disclosure in this case is discretionary and will depend on the custodian's belief that reasonable grounds exist to make the disclosure, adding a subjective decision making layer. It is up to the individual deciding whether to disclose to determine what evidence is sufficient to meet the standard of "reasonable grounds to believe" and what constitutes a "risk of serious bodily harm to a person or group of persons."

The sections permitting disclosure to public health officials are intended to enable where necessary the free flow of information for the protection of the public. But they are far from clear and the decision to disclose will, in many cases, require the health information custodians to use their discretion. The problem is that health information custodians with any doubt about their ability to disclose will naturally err on the side of nondisclosure, having regard to the presumption of nondisclosure created by the privacy culture and the severe penalties against violating the privacy laws.

Subsection 72(1) of the *Personal Health Information Protection Act* provides that anyone who "wilfully collects, uses or discloses personal health information in contravention of this Act or its regulations" is guilty of an offence. Section 65 provides that damages may be sought where there has been a violation of the Act, either as a consequence of an order by the Commissioner to remedy a violation or as a result of conviction under s. 72(1).[196] A breach of s. 72 carries the potential for significant monetary penalities,[197] including a fine of up to $50,000 for an individual like a nurse and up to $250,000 for a corporation like a hospital. Officers, members, employees or other agents of a corporation may also be personally subject to prosection under s. 72(3) if they authorized the offence or had the authority to prevent it, and knowingly refrained from doing so.

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[196] Section 65 provides:

Damages for breach of privacy

(1) If the Commissioner has made an order under this Act that has become final as the result of there being no further right of appeal, a person affected by the order may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of a contravention of this Act or its regulations. 2004, c. 3, Sched. A, s. 65 (1).

Same

(2) If a person has been convicted of an offence under this Act and the conviction has become final as a result of there being no further right of appeal, a person affected by the conduct that gave rise to the

It is essential to clarify the privacy legislation by way of a simple amendment lest it be blamed for nondisclosure of vital information about infectious diseases.

Consider the tragic case in British Columbia of the young university student who committed suicide in February, 2004. University staff and health professionals, out of a mistaken belief that privacy legislation prevented disclosure, did not advise her mother of a previous suicide attempt, preventing her from taking action that might stop another attempt.[198] British Columbia's privacy legislation contained provisions that could have arguably authorized the disclosure.[199] As one newpaper editorial described the problem with the legislation:

> That these parts of the law [the sections that could have authorized the disclosure] can be interpreted in different ways presents a problem for

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offence may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of the conduct. 2004, c. 3, Sched. A, s. 65 (2).

Damages for mental anguish

(3) If, in a proceeding described in subsection (1) or (2), the Superior Court of Justice determines that the harm suffered by the plaintiff was caused by a contravention or offence, as the case may be, that the defendants engaged in willfully or recklessly, the court may include in its award of damages an award, not exceeding $10,000, for mental anguish.

[197] Subsection 72(2) provides:

Penalty

A person who is guilty of an offence under subsection (1) is liable, on conviction,

(a) if the person is a natural person, to a fine of not more than $50,000; and

(b) if the person is not a natural person, to a fine of not more than $250,000. 2004, c. 3, Sched. A, s. 72 (2).

[198] Vancouver Sun, Editorial, July 13, 2004.

[199] Consider, for example, the following sections of the *Personal Information Protection Act* (British Columbia).

18(1) An organization may only disclose personal information about an individual without the consent of the individual, if

> (k) there are reasonable grounds to believe that compelling circumstances exist that affect the health or safety of any individual and if notice of disclosure is mailed to the last known address of the individual to whom the personal information relates.
>
> (l) the disclosure is for the purpose of contacting next of kin or a friend of an injured, ill or deceased individual.

> hospital staff in that they're unlikely to act on their own interpretations for fear of running afoul of the law.[200]

The sentiment heard by the Commission in respect of Ontario's privacy legislation is that people are confused and intimidated by its complexity. The prevailing attitude seems to be, when in doubt, do not disclose. When the health of the public is at risk, this nondisclosure born of doubt and confusion cannot be permitted to continue.

Recommendation

The Commission therefore recommends that:

- **Section 39 of the *Personal Health Information Protection Act* be amended to include:**
    - **A health information custodian shall disclose personal health information about an individual, to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act*.**

Disclosures by a Medical Officer of Health or the Chief Medical Officer of Health

The recommended amendments, set out above and below, will clarify the power of a health care custodian to disclose information to a medical officer of health or the Chief Medical Officer of Health. The problem remains of the ability of a medical officer of health or the Chief Medical Officer of Health to disclose information in respect of a person against whom an application, order, certificate or report is made in respect of a communicable disease. This is a power that is integral to their ability to protect the public.

Consider an example of a person infected with a virulent disease, such as SARS, against whom the medical officer of health issues an order under s. 22, requiring that they isolate themselves to avoid spreading the disease to others in the community. If that person ignores the order and continues to move about in the community, it is unclear if the medical officer of health can share with any person any information about that person, that will or is likely to identify them.

Consider the example of the woman with TB who managed to evade public health authorities, avoid apprehension under a s. 35 order, and leave Canada to travel to another country. If the medical officer of health in the jurisdiction which obtained the order was unable to share personal identifying information with federal public health officials, border officials and quarantine officials in the federal government, they could not apprehend her as she attempted to re-enter Canada.

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[200] Vancouver Sun, Editorial, July 13, 2004.

Although both disclosures might be permitted under the *Personal Health Information Protection Act,*[201] s. 39(1) of the *Health Protection and Promotion Act* contains a prohibition on disclosure of the name or identifying information of a person against whom an application, order, certificate or report under the communicable disease provisions of the Act have been made. Subsection 39(1) provides:

> No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent.

Subsection 2 sets out exceptions to the prohibition of disclosure in s. 39(1). It provides:

> Subsection (1) does not apply,
>
> > (a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;
> >
> > (b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;
> >
> > (c) where the disclosure is made for the purposes of public health administration;
> >
> > (d) in connection with the administration of or a proceeding under this Act, the Regulated Health Professions Act, 1991, a health profession Act as defined in subsection 1 (1) of that Act, the Public Hospitals Act, the Health Insurance Act, the Canada Health Act or the Criminal Code (Canada), or regulations made thereunder; or
> >
> > (e) prevent the reporting of information under section 72 of the Child and Family Services Act in respect of a child who is or may be in need of protection.

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[201] For example, s. 40(1) of the *Personal Health Information Protection Act*, discussed in greater detail below, permits disclosure if "the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons." Subsection 39(2)(b) of the *Personal Health Information Protection Act* permits disclosure of personal health information by a health information custodian to a public authority that is similar to the Chief Medical Officer of Health or a medical officer of health, that is established under the laws of Canada, some other province or territory, if the disclosure is made for a purpose that is substantially similar to a purpose of the *Health Protection and Promotion Act*. Section 2 of the *Health Protection and Promotion Act* includes the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario. A medical officer of health is defined as a health information custodian under s. 3 of the *Personal Health Information and Protection Act*.

For a medical officer of health or the Chief Medical Officer of Health to disclose identifying or potentially identifying information in respect of a person against whom an order, application, certificate or report has been made under Part IV (communicable diseases) of the Act, they must fit within one of these exceptions. Paragraph (c) appears to be the only provision that might authoritze disclosure in the circumstances described above.

This means that unless the medical officer of health can be confident that such a disclosure is for the purposes of "public health administration," they would be disclosing that information on the hope and a prayer that they are correct in their interpretation of the phrase. One public health lawyer descibed its lack of clarity to the Commission:

> There is a need to clarify what is meant by public health administration. Many might say that public health administration is meant to be interpreted to mean that you can tell your staff, for example those who are helping you draft orders, as opposed to meaning the medical officer of health can do what he or she needs to do to protect the public. It is not really very clear.

It is far from clear that this vague terminology allows the medical officer of health or the Chief Medical Officer of Health to do what is necessary to protect the public.

The Canadian Oxford Dictionary defines "administration" as "a management of a business" or "management of public affairs". It is far from clear that this would permit the disclosure of identifying or potentially identifying information to anyone outside of the local health unit of the Ministry of Health.

As one public health lawyer said:

> There are a lot of circular arguments. The bottom line is that would probably be fine to disclose and people might not get wound up about it but it would be nice to be clear.

The Chief Medical Officer of Health and medical officers of health must be able to share identifying information, where necessary to protect the public. The fact that the person has been the subject of an application, order, certificate or report should not prohibit disclosure, provided it is in compliance with the privacy legislation. This is particularly vital in respect of disclosures to public health officials in other provinces or in the federal government.

As Dr. Basrur told the Justice Policy Committee:

> It is not quite clear as yet how the chief medical officer of health in this case can and should report that information more broadly to, say, Health Canada or other authorities, and whether that can be nominal, or named, information with personal information in it or whether it must be anonymized information. So when you're looking at things that should be clearer in the future – again, I can expect you'll hear this from Justice Campbell in his

> interim report – that is one of those areas that would benefit from greater clarity.[202]

Recommendations

The Commission therefore recommends that:

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to any person where it is necessary to investigate or prevent the spread of a communicable disease.**

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to a public health authority as described in s. 39(2)(b) of the *Personal Health Information Protection Act.***

The Need for Clarity

Lawyers who advise health professionals and hospitals whether they should disclose will likely bear in mind the severe penalties in the privacy legislation and lean towards nondisclosure if there is any lack of clarity about the legal duty to disclose. Another risk is that the complexity of the law may enable individuals or institutions who do not want to disclose information, for whatever reason, to use the legislation as a shield and delay or breach their disclosure obligations.

The Ministry of Health and Long-Term Care, in a submission to the Commission, stated:

> It is our view that the new Personal Health Information Protection Act, 2004, (PHIPA) resolves any concerns relating to "legal obstacles" and "lack of clarity" as outlined in your attachment entitled "Possible Issues Re: Legislation." The passage of PHIPA received unanimous support in the Legislature. During the Committee hearings on the bill, there was no criticism that the proposed Act failed to address the concerns raised during the SARS outbreak.

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[202] Justice Policy Committee, Public Hearings, August 18, 2004, p. 139.

While the legislation may appear clear to those who wrote it, the Commission has heard from many groups and individuals who find it unclear and confusing. As for the Committee hearings, one close observer of the proceedings told the Commission that the impact of the legislation on a new SARS-like outbreak was not discussed.

Consider the case of the hospital that took the position that there was not only an absence of legal authority to report cases of febrile respiratory illness to public health officials, but that to do so constitutes an illegal contravention of privacy legislation. Their interpretation of the legislation prohibited disclosure. Although no infection resulted from this position, it demonstrates that some will resist any disclosure to public health, however reasonable, unless an explicit legal duty can be demonstrated conclusively.

One professional organization described the need for clarity:

> … the patient's right to confidentiality does NOT override the public good. In providing care to any patient with a potentially infectious or contagious disease, all health care professionals (physicians, nurses, paramedics) and institutions MUST share such information in order to safeguard staff and to prevent further spread of the disease in question. The professionals involved are obligated to treat such information as confidential. Processes should be in place to address those individuals and/or institutions that fail to address this or who fail, in a timely manner, to provide appropriate confidentiality for the patient information that has been shared with them.

Expanded reporting duties and expanded information gathering and sharing powers under the *Health Protection and Promotion Act* are only part of the solution. Information necessary to enable public health officials to protect the public must not be blocked by the misunderstandings created by the complexities of privacy legislation. This is not to suggest that the provisions in the Act are not helpful, or thoughtfully drafted. But the duty to disclose information to public health officials, free from penalty under the privacy legislation, must be clear. It must be clear that if there is a duty to report a matter to public health, that duty prevails over any other consideration. As one health care provider told the Commission:

> … specific legislation that clearly defines which act supercedes another in given situations will be important.

The Ministry, in a letter to the Commission,[203] although reluctant to agree that changes are needed in the *Personal Health Information Protection Act*, acknowledged that the legislation is complex to the point that it would encourage health care providers to seek legal advice instead of acting immediately to comply with a valid demand for information under the *Health Protection and Promotion Act*:

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[203] Letter from Mr. Phil Hassen, Deputy Minister of Health and Long-Term Care, to the Mr. Justice Archie Campbell, SARS Commission, August 4, 2004. See Appendix H to this report.

> If Ontario had had a PHIPA in place during the SARS outbreak, all of these provisions that have been highlighted would have provided greater clarity around information sharing. PHIPA, therefore, addresses the perceived "lack of clarity" or "legal obstacles" facing various health information custodians during the SARS outbreak. The legislation, however, is complex as the rules cover a broad range of custodians and recipients. We cannot say, therefore, that this new Act is so clear that it would preclude health care providers from "seeking legal advice and direction instead of acting immediately." Even if legislation were to be written in mandatory language, this may not alleviate concerns of those who need to rely on it for authority to do something or refrain from doing something. PHIPA does clearly set out that custodians, such as hospitals, nursing homes, nurses and doctors, can disclose personal health information to the Chief Medical Officer of Health or a medical officer of health or a person with similar authority in another province and ultimately does provide protection from liability to those providers who exercise their discretion reasonably in the circumstances.

The point is not that there is anything wrong with legal advice. In the early stages of the life of a statute a measure of education is necessary. The problems reviewed here, however, require clarifying amendments as well as education. The point is that the law should be so clear that lawyers do not have to argue with each other in the middle of an infectious disease outbreak about the obligation to disclose information to public health. Notwithstanding the logic of those who are intimately familiar with the exquisite legal intricacies of the privacy legislation, it must be remembered that the life of the law is not logic, but experience. Experience tells us that if the privacy law does not clearly authorize disclosure where legally required for public health purposes, such disclosure will be impeded.

As Dr. Henry told the Justice Policy Committee:

> The one other caveat I wanted to bring up is the whole protection of privacy of health information. As you know, Bill 31 is going through the legislative process right now and it will in some ways severely curtail our ability to actually track and monitor certain diseases. I think we need to build our IT systems around protection of personal health information, but also somehow strike the balance between being able to use that information for the broader good and the prevention of transmission of disease. Right now that balance is a little unclear.[204]

What is required is a simple statutory override to make clear that the duty to disclose to public health officials prevails over the privacy legislation. Even those who resist amendment agree that the duty to disclose to public health officials prevails over the privacy legislation. Why not say it clearly in the legislation?

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[204] Justice Policy Committee, Public Hearings, August 18, 2004, p. 151.

Override provisions are not unheard of in statutes and indeed the *Health Protection and Promotion Act* itself contains one. The *Health Protection and Promotion Act* has been amended to set out the duties of disclosure and nondisclosure of a medical officer of health in respect of reports received about environmental or occupational health hazards, and the statute now provides an explicit override of the privacy legislation. Subsection 11(3) provides:

> The obligation imposed on the medical officer of health under subsection (2) prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*. 2004.[205]

Both the *Personal Health Information Protection Act* and the *Health Protection and Promotion Act* must make it clear that the reporting obligations and information sharing powers set out in the *Health Protection and Promotion Act* prevail.

The Commission therefore recommends that the *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from disclosing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act.*

The Commission recommends that both the *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to provide that in the event of any conflict between the two statutes, the disclosure duties in the *Health Protection and Promotion Act* prevail.

The *Personal Health Information Protection Act* provides protection from punishment in those cases where a health information custodian makes a reasonable disclosure, in good faith reliance on the *Personal Health Information Protection Act,* that later turns out should not have been made. Section 71(1) provides:

> 71(1). No action or other proceeding for damages may be instituted against a health information custodian or any other person for,

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[205] The complete provision reads as follows:

> 11(1) Where a complaint is made to a board of health or a medical officer of health that a health hazard related to occupational or environmental health exists in the health unit served by the board of health or the medical officer of health, the medical officer of health shall notify the ministry of the Government of Ontario that has primary responsibility in the matter and, in consultation with the ministry, the medical officer of health shall investigate the complaint to determine whether the health hazard exists or does not exist.
>
> (2) The medical officer of health shall report the results of the investigation to the complainant, but shall not include in the report personal health information within the meaning of the *Personal Health Information Protection Act, 2004* in respect of a person other than the complainant, unless consent to the disclosure is obtained in accordance with that Act.
>
> (3) The obligation imposed on the medical officer of health under subsection (2) prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*.

> (a) anything done, reported or said, both in good faith and reasonably in the circumstances, in the exercise or intended exercise of any of their powers or duties under this Act; or
>
> (a) any alleged neglect or default that was reasonable in the circumstances in the exercise in good faith of any of their powers or duties under this Act.

While this provides a measure of protection, similar protection should be extended to those who disclose in reliance on the *Health Protection and Promotion Act*.[206]

The Commission recommends that the *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian will be exempt from liability.

Recommendations

The Commission therefore recommends that:

- **The *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from disclosing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act*.**
- **The *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to provide that in the event of any conflict between the two statutes, the disclosure duties in the *Health Protection and Promotion Act* prevail.**
- **The *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian is exempt from liability.**

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[206] The *Health Protection and Promotion Act* does exempt from liability a person who makes, in good faith, a report of a communicable disease under the Act. Subsection 95(4) provides:

> No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV.

This protection does not clearly protect them from liability under privacy legislation. Morevoer, if the reporting powers are broadened as recommended in Chapters 5 and 6 of this report, the protection afforded in s. 95(4) will have to be similarly broadened to protect any report authorized under the *Health Protection and Promotion Act*.

Disclosure for Research

A number of groups and individuals expressed concern to the Commission about the process by which scientists, during a health emergency, would have access to personal health information urgently required for the purpose of research to fight the emergency. During SARS, it was critical for scientists to have access to data to learn more about the cause of SARS and research possible treatment.

Section 44 of the *Personal Health Information Protection Act* sets out the rules in respect of disclosure of personal health information for the purposes of research.[207]

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[207] Section 44 provides:

> Disclosure for Research
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> 44(1) A health information custodian may disclose personal health information about an individual to a researcher if the researcher,
>
> (a) submits to the custodian,
>
> (i) an application in writing,
>
> (ii) a research plan that meets the requirements of subsection (2), and
>
> (iii) a copy of the decision of a research ethics board that approves the research plan; and
>
> (b) enters into the agreement required by subsection (5).
>
> Research Plan
>
> (2) A research plan must be in writing and must set out,
>
> (a) the affiliation of each person involved in the research;
>
> (b) the nature and objectives of the research and the public or scientific benefit of the research that the researcher anticipates; and
>
> (c) all other prescribed matters related to the research.
>
> Consideration by Board
>
> (3) When deciding whether to approve a research plan that a researcher submits to it, a research ethics board shall consider the matters that it considers relevant, including,
>
> (a) whether the objectives of the research can reasonably be accomplished without using the personal health information that is to be disclosed;
>
> (b) whether, at the time the research is conducted, adequate safeguards will be in place to protect the privacy of the individuals whose personal health information is being disclosed and to preserve the confidentiality of the information;
>
> (c) the public interest in conducting the research and the public interest in protecting the privacy of the individuals whose personal health information is being disclosed; and

While long-term research is important, SARS revealed the importance of immediate short-term research. Rules and guidelines that permit the fast tracking of approval for disclosure of personal health information where research is urgently required are needed for the protection of the public's health. As one health organization submitted to the Commission:

> … the *Personal Health Information Protection Act* needs to address the collection and use of confidential health information for research purposes during an infectious disease outbreak. During a health emergency, pressure may be brought to bear on hospital Research Ethics Boards for expedited approval of research and investigations designed to gain a better understanding of a new infectious disease. While such expediency is understandable, clear guidelines for the fast track approval of such studies is required, and the emergency sharing of health information on which the study depends. This is extremely critical when dealing with new agents of illness, where research findings will enable control of the outbreak.

Recommendation

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care, in consultation with the appropriate community, establish fast-tracking approval procedures for access to personal health information for the purposes of urgently required research, to enable health care custodians to provide access to data in a timely manner, without fear of violating privacy legislation.**

Privacy Safeguards

Safeguards are required to ensure that personal health information does not get disclosed beyond public health professionals who have public health duties.[208] During SARS, one medical officer of health reported that functionaries in the Minister's office, who had no public health duties, were at times privy to personal health information. They questioned why this was the case and maintained that under no circumstances would this be necessary:

(d) whether obtaining the consent of the individuals whose personal health information is being disclosed would be impractical.

Decision of Board

(4) After reviewing a research plan that a researcher has submitted to it, the research ethics board shall provide to the researcher a decision in writing, with reasons, setting out whether the board approves the plan, and whether the approval is subject to any conditions, which must be specified in the decision.

[208] The *Health Protection and Promotion Act* provides some safeguards to protect personal health information in the hands of public health officials. For example, s. 39 of the Act, discussed in the previous chapter.

> We sat in the SARS Committee meetings and I recall [an individual] from the Minister's office while we were discussing nominal information but very detailed clinical information – we were going through our line list of individuals – I thought it was completely outrageous … Non-health professionals, i.e. … Ministers and political staff, except those in the public health division who fall under confidentiality provisions of *HPPA*, should have no access to personal health information in times of crisis.

One professional organization described this problem to the Commission:

> During SARS multiple reports of the improper sharing of confidential health information, being requested by political staff who had no clear need for the information, and open teleconference discussions of nominal information on patients where the teleconference participants were unclear, were had. This is unacceptable, placing the individual and their care provider in a difficult position, should the information be inappropriately disseminated further.

The power to obtain personal health information brings with it strong obligations to safeguard its privacy. Medical officers of health, as health information custodians, are required under the *Personal Health Information Protection Act* to have in place practices that comply with the requirements of the Act and regulations:

> 10(1). A health information custodian that has custody or control of personal health information shall have in place information practices that comply with the requirements of this Act and its regulations. 2004, c. 3, Sched. A, s. 10(1).

These practices should be uniform across the province and should ensure that only those public health officials who require access to personal health information to perform their duties under the *Health Protection and Promotion Act* have access to such information.

Recommendation

The Commission therefore recommends that:

- **The Chief Medical Officer of Health review and, if necessary, strengthen the internal protocols and procedures now in place to ensure effective privacy safeguards for personal health information received by public health authorities.**

Conclusion

Health professionals and public health professionals should not have to negotiate through lawyers to enable the disclosure of information required by law. There should be no avenue for delay. In an infectious disease outbreak, time is of the essence. Public health physicians and staff require access to personal health information to enable them to identify cases of disease and to investigate and manage an outbreak. Medical officers of health must be able to obtain the information they need to do their job, the disclosure of which is required by law. Confusion around complex privacy laws must not impede the vital flow of this legally required information. Simple amendments, which in no way affect the integrity of privacy legislation, are required to fix this problem.

Recommendations

The Commission therefore recommends that:

- **Section 39 of the *Personal Health Information Protection Act* be amended to include:**
    - **A health information custodian shall disclose personal health information about an individual, to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act.***
- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to any person where it is necessary to investigate or prevent the spread of a communicable disease.**
- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to a public health authority as described in s. 39(2)(b) of the *Personal Health Information Protection Act.***
- **The *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from providing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act.***
- **The *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to state that in the event of any conflict between the two statutes, the duties in the *Health Protection and Promotion Act* prevail.**

- The *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian will be exempt from liability.

- The Ministry of Health and Long-Term Care, in consultation with the appropriate community, establish procedures for the fast-tracking of approval of access to personal health information for the purposes of urgently required research, to enable health care custodians to provide access to data in a timely manner, without fear of violating privacy legislation.

- The Chief Medical Officer of Health review, and if necessary strengthen, the internal protocols and procedures now in place to ensure effective privacy safeguards for personal health information received by public health authorities.

7. Whistleblower Protection

The Case for Whistleblower Protection

Ontario health care workers need whistleblower protection to ensure that public health risks are reported promptly to public health authorities without fear of consequences. Without this protection, fear of workplace consequences might discourage the timely disclosure of public health risk. Front line health care workers made enormous sacrifices during SARS. They are entitled to be protected when they raise an alarm to protect public health.

As one nurse told the Commission:

> I want to have the freedom to speak out, so that I'm not worried I might lose my job.

Nurses and other health care workers should be able to alert public health authorities to infection control and disease outbreak problems within hospitals, nursing homes, and the like. If instruments are not being properly sterilized, if a hospital is not actively investigating reports of a possible infectious outbreak, health care workers should be able to report it to public health officials without fear of personal consequences. Workers who disclose information vital to protecting the public's health should be assured that they are protected legally against any form of employer reprisal or workplace consequence.

This chapter will focus on the need to add public health whistleblower protection to the *Health Promotion and Protection Act*. As for other whistleblower issues, there are already whistleblower provisions in the *Occupational Health and Safety Act*,[209] and the larger question of general whistleblower protection for public employees is beyond the scope of this Commission.

Subsection 95(4) of the *Health Protection and Promotion Act* does allow that "no action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV." However, it is of limited protection. As noted in a submission to the Commission:

> The *Health Protection and Promotion Act* should be amended to provide reprisal protection for employees who, in good faith, raise concerns about how a public health risk is being addressed. The Act does provide that "No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV," *(Health Protection and Promotion Act,* R.S.O. 1990, c. H.7, s. 95 (4)), but that protection only deals with reporting specific occurrences, and not with raising concerns about how such an occurrence is being addressed by the public health system. This lack of real

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[209] R.S.O. 1990, c. O-1.

> "whistleblowing protection" for public health workers is a gap in Ontario's health protection system.

Fear of reprisal is very real. Many nurses and other health care workers expressed fear of workplace consequences if it became known that they were being interviewed confidentially by the Commision. In some cases health care workers agreed to be interviewed on a confidential basis only after they understood that their disclosures to the Commission were protected by the whistleblower protection in Ontario's *Public Inquiries Act,*[210] which governs this Commission: Section 9.1 provides

> 1. No adverse employment action shall be taken against any employee or any person because the employee, acting in good faith, has made representations as a party or has disclosed information either in evidence or otherwise to a commission under this Act or to the staff of a commission.
>
> 2. Any person who contrary to subsection (1) takes adverse employment action against an employee is guilty of an offence and on conviction is liable to a fine of not more than $5,000.
>
> 3. This section applies despite any other Act and the oath of office of a Crown employee is not breached where information is disclosed as described in subsection (1).[211]

Even with this protection under the *Public Inquiries Act* some witnesses were inititally reluctant to speak to the Commission. Their fear of workplace retaliation was more immediate to them than the seemingly remote protection provided by the statute.

The measure of the concern was expressed by one reluctant witness, a health care worker, who was "afraid of losing my job." Even after being briefed on the confidential nature of the Commission process, and the whistleblower protection in the *Public Inquiries Act,* the witness said:

> There are lots of other reasons for firing people.

The initial reluctance of some health care workers to speak confidentially to the Commission, even after the *Public Inquiries Act* whistleblower protection was explained, underlines their feelings of vulnerability even when given a measure of legal protection. Those feelings of vulnerability are necessarily greater when there is no legal protection at all in respect of a disclosure of a public health danger. Other than the protection when reporting a reportable or communicable disease as required by s. 95(4)[212] of the *Health*

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[210] R.S.O. 1990, c. P-41.

[211] These amendments received Royal Assent on June 23, 2003, following submissions from OPSEU calling for whistle-blower protection in the Walkerton Inquiry.

[212] Subsection 95(4) provides:

Protection and Promotion Act, health care workers who disclose a public health hazard have no protection at all from workplace reprisal.

Health care work can be tough and demanding. The demanding work may strain relationships between workers and supervisors. The atmosphere and pressures on the hospital floor may be less conducive to appropriate disclosure than the higher-ups may think. The fear of retaliation exists and is very real in the minds of those who might have information highly relevant to the protection of the public against an outbreak of infectious disease. These fears have the potential to impede the reporting of information that is vital to the protection of other health care workers and the public, particularly in the case of an infectious disease, where timely reporting and action is critical.

Barb Wahl, the then President of the Ontario Nurses' Association (ONA),[213] in a statement at the SARS Commission public hearings: emphasized the need for whistleblower protection:

> Nurses need whistle-blower protection so that they can go elsewhere with the information they have. They need respect and recognition as professionals and essential members of the health care team. Nurses are tired of being shunted aside and disregarded. It's another reason they're leaving the profession. They see they're not included in the decisions and, as a result, they feel they and their patients are not safe.[214]

Adeline Falk-Rafael, President of the Registered Nurses Association of Ontario (RNAO)[215] noted its long standing advocacy of whistleblower protection for health care workers as an important safety valve in the health care system:

> Immediately introduce whistleblower legislation to ensure that nurses and other health care workers can express their concerns without fear of reprisal from their employer. RNAO first requested this legislation from the Premier of Ontario in March of 1998. Failure to implement this legislation has meant that an important safety valve is missing from our health care system.[216]

> No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV.

[213] The Ontario Nurses' Association (ONA) is the trade union that represents 50,000 registered nurses and allied health professionals working in hospitals, long-term care facilities, public health, community agencies and industry throughout Ontario (Source: ONA website). On January 1, 2004, Linda Haslam Stroud succeeded Wahl as ONA President.

[214] SARS Commission, Public Hearings, September 29, 2003.

[215] The Registered Nurses Association of Ontario (RNAO) is the professional association representing over 20,000 registered nurses in Ontario.

[216] SARS Commission, Public Hearings, September 29, 2003.

Whistleblower protection is advocated by the unions that represent Ontario health care workers.

The Canadian Union of Public Employees (CUPE),[217] in a written recommendation to the Commission, stated "Whistleblower legislation is necessary for any employees who feel an employer is putting themselves or the public at risk."

The Ontario Public Service Employees' Union (OPSEU),[218] in recommending whistleblower protection for health care workers, made the following submission to the Commission:

> Any person with public health responsibilities should be able to bring their good faith concerns about public health risks to the attention of an independent public authority, and, if necessary, the public, without facing reprisal or retaliation from vested interests. The leading Canadian study makes the following observation concerning federal public servants:
>
> > An effective regime for the identification, disclosure and correction of wrongdoing … provides public servants with the tools and support they need to reveal and correct instances where conduct and decision-making fall short of the high standards expected in public institutions. In addition, a trusted disclosure regime can make a significant contribution to public service morale and conduct, and to public confidence in government. (Government of Canada, Report of the Working Group on Disclosure of Wrongdoing, 2003, Executive Summary: on Treasury Board website.)
>
> These comments apply equally to persons employed in public sector health functions.

OPSEU made the following recommendation to the Commission:

> Amend the *Health Protection and Promotion Act* to add a provision similar to the *Environmental Bill of Rights*, Section 105, but broadened to include protection against reprisals: where the employee is employed by an enforcement agency, for bringing the matter to public attention after the matter was first brought to the attention of the employer of that person.

Those concerned about the need for whistleblower protection will experience a shock of recognition in the findings made by Associate Chief Judge Murray Sinclair, in the Report of the Manitoba Paediatric Cardiac Surgery Inquest. The inquiry looked at the deaths of 12 infants at a Winnipeg Hospital and concluded that five were preventable, three "were still surrounded by more questions than answers," and only one had been acceptably explained. Judge Sinclair found:

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[217] CUPE is Canada's largest union. With more than half a million members across Canada, CUPE represents workers in health care, education, municipalities, libraries, universities, social services, public utilities, transportation, emergency services and airlines. (Source: CUPE website).

[218] OPSEU is the third largest union in Ontario, with approximately 100,000 full- and part-time members, nearly 500 locals, and 20 offices across Ontario. OPSEU represents Ontario public service employees, education workers, health workers, social services workers, justice workers and some municipal employees

> The evidence suggests that because nursing occupied a subservient position within the HSC structure, issues raised by nurses were not always treated appropriately.[219]

He wrote:

> Historically, the role of nurses has been subordinate to that of doctors in our health-care system. While they are no long[er] explicitly told to see and be silent, it is clear that legitimate warnings and concerns raised by nurses were not always treated with the same respect or seriousness as those raised by doctors. There are many reasons for this, but the attempted silencing of members of the nursing profession, and the failure to accept the legitimacy of the concerns, meant that serious problems in the paediatric cardiac surgery programme were not recognized or addressed in a timely manner. As a result, patient care was compromised.[220]

Judge Sinclair said:

> It is necessary to put in place structures that ensure that all staff can make their concerns known without fear or reprisal. It is also important to ensure that the structure of the HSC be adjusted to ensure that the position of nursing does not continue to be a subservient one.

To this end, he recommended that:

> The Province of Manitoba consider passing 'whistle blowing' legislation to protect nurses and other professionals from reprisals stemming from their disclosure of information arising from a legitimately and reasonably held concern over the medical treatment of patients.

Everything said in that report about the barriers to disclosure, and the need for whistleblower protection, applies to the concerns expressed by Ontaro health care workers. All Ontario workers now enjoy a limited protection in respect of the disclosure of workplace health and safety hazards. The Ontario *Occupational Health and Safety Act*[221] whistleblower provision provides:

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[219] Mr. Justice Murray Sinclair, The Report of the Manitoba Paediaric Cardiac Surgery Inquest, "An Inquiry Into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994," November 27, 2000, Chapter 10, p. 1 (electronic version), (subsequently referred to as the Sinclair Report).

[220] The Sinclair Report, Chapter 10, p. 1 (electronic version).

> (50) No employer or person acting on behalf of an employer shall,
> (a) dismiss or threaten to dismiss a worker;
> (b) discipline or suspend or threaten to discipline or suspend a worker;
> (c) impose any penalty upon a worker; or
> (d) intimidate or coerce a worker,
> because the worker has acted in compliance with this Act or the regulations or an order made thereunder, has sought the enforcement of this Act or the regulations or has given evidence in a proceeding in respect of the enforcement of this Act or the regulations or in an inquest under the *Coroners Act*.

The Ontario workplace safety disclosure provisions require that the worker seek compliance with the statute, as opposed to simply disclosing a concern about a hazard, before the worker attracts whistleblower protection. The focus of this legislation is not on public health but rather on workplace safety, a matter to be dealt with in the final report.

It is important to distinguish between occupational health and safety whistleblower protection and public health whistleblower protection directed to health care workers who make a disclosure to a medical officer of health in respect of a public health risk. Obvious examples include disclosure of a dangerous infection control practice in a hospital, or a cluster of cases that warrants investigation for evidence of an infectious disease outbreak.

A number of statutes, both provincial and federal, provide whistleblower protection. For example, in addition to the *Occupational Health and Safety Act*, Ontario's *Environmental Bill of Rights* makes it an offence for any employer to take reprisals against an employee where the latter has, in good faith, complained, provided information for an investigation or review or participated in a process under the Act.[222] Similarly, the Ontario *Labour Relations Act, 1995*,

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[221] R.S.O. 1990, c. O-1.

[222] R.S.O. 1993, s. 105(1) provides:

> Any person may file a written complaint with the Board alleging that an employer has taken reprisals against an employee on a prohibited ground.
>
> Reprisals mean:
>
> > (2) For the purposes of this Part, an employer has taken reprisals against an employee if the employer has dismissed, disciplined, penalized, coerced, intimidated or harassed, or attempted to coerce, intimidate or harass, the employee.
>
> Subsection (3) sets out the prohibited grounds:
>
> > (3) For the purposes of this Part, an employer has taken reprisals on a prohibited ground if the employer has taken reprisals because the employee in good faith did or may do any of the following

makes it an offence for either the employer or the Union to take employment action against a person who has made a complaint under the Act.[223]

There are somewhat similar whistleblower provisions in federal legislation such as the *Canadian Environmental Protection Act, 1999.*[224]

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1. Participate in decision-making about a ministry statement of environmental values, a policy, an Act, a regulation or an instrument as provided in Part II.

2. Apply for a review under Part IV.

3. Apply for an investigation under Part V.

4. Comply with or seek the enforcement of a prescribed Act, regulation or instrument.

5. Give information to an appropriate authority for the purposes of an investigation, review or hearing related to a prescribed policy, Act, regulation or instrument.

6. Give evidence in a proceeding under this Act or under a prescribed Act.

[223] S.O., 1995, c. 1, Sched. A, s. 87(1) provides:

(1) No employer, employers' organization or person acting on behalf of an employer or employers' organization shall,

(a) refuse to employ or continue to employ a person;

(b) threaten dismissal or otherwise threaten a person;

(c) discriminate against a person in regard to employment or a term or condition of employment; or

(d) intimidate or coerce or impose a pecuniary or other penalty on a person,

because of a belief that the person may testify in a proceeding under this Act or because the person has made or is about to make a disclosure that may be required in a proceeding under this Act or because the person has made an application or filed a complaint under this Act or has participated in or is about to participate in a proceeding under this Act.

Same

(2) No trade union, council of trade unions or person acting on behalf of a trade union or council of trade unions shall,

(a) discriminate against a person in regard to employment or a term or condition of employment; or

(b) intimidate or coerce or impose a pecuniary or other penalty on a person,

because of a belief that the person may testify in a proceeding under this Act or because the person has made or is about to make a disclosure that may be required in a proceeding under this Act or because the person has made an application or filed a complaint under this Act or has participated in or is about to participate in a proceeding under this Act.

[224] R.S.C. 1999, c. 33, s. 16. provides:

Whistleblower protection of a more general nature has been advocated in Ontario from time to time. A complicated series of 1993 amendments to the *Public Service Act*,[225] passed by the Legislative Assembly, would have provided general protection for Ontario government employees against retaliation for disclosing allegations of serious government wrongdoing and would also have provided a means for making those allegations public. The legislation proposed an elaborate structure of advice, disclosure, review, reports, notices, reviews, exemptions, submissions, consents, referrals, complaints, arbitrations, settlements, and appeals involving an independent counsel as an officer of the Legislative Assembly. Since its enactment 11 years ago no government has ever proclaimed it in force. The Act applies primarily to government employees and even if proclaimed would withhold protection from most health care workers who are not employed by a government institution.

A more recent Ontario initiative was the introduction into the Legislative Assembly on May 23, 2002, by Shelley Martel M.P.P., of Bill 27, "*An Act to promote patients' rights and to increase accountability in Ontario's health care system.*" This private members' public bill called for the appointment of a Health Care Standards Commissioner, whose function would include, among other things the administration of a system of whistleblower protection.[226] The Act

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(1) Where a person has knowledge of the commission or reasonable likelihood of the commission of an offence under this Act, but is not required to report the matter under this Act, the person may report any information relating to the offence or likely offence to an enforcement officer or any person to whom a report may be made under this Act.

(2) The person making the report may request that their identity, and any information that could reasonably be expected to reveal their identity, not be disclosed.

(3) No person shall disclose or cause to be disclosed the identity of a person who makes a request under subsection (2) or any information that could reasonably be expected to reveal their identity unless the person authorizes the disclosure in writing.

(4) Despite any other Act of Parliament, no employer shall dismiss, suspend, demote, discipline, harass or otherwise disadvantage an employee, or deny an employee a benefit of employment, by reason that

> (*a*) the employee has made a report under subsection (1);
>
> (*b*) the employee, acting in good faith and on the basis of reasonable belief, has refused or stated an intention of refusing to do anything that is an offence under this Act; or
>
> (*c*) the employee, acting in good faith and on the basis of reasonable belief, has done or stated an intention of doing anything that is required to be done by or under this Act.

[225] R.S.O. 1990, c. P-47.

[226] The proposed whistleblower section provides:

4(1) The purposes of this section are,

> to protect employees of providers of health care services from adverse employment action for disclosing allegations of noncompliance with the Patients' Bill of Rights or a health care standard; and
>
> to provide the means for making those allegations public.

was never passed.[227] The focus of that proposal was on patients' rights and health care standards generally, not on public health risk in particular. It involved a complex system of reporting, including a separate agency to receive and invesigate complaints..

More recently, two pieces of federal legislation one enacted and one pending, provided whistleblower protection in the federal domain.

The first, Bill C-12, repealed and replaced the former *Quarantine Act*, with *"An Act to prevent the introduction and spread of communicable diseases."* This new *Quarantine Act* was passed on February 10, 2005. It contains a section which provides:

> 54. (1) A person who, in good faith, reports to a screening officer, a quarantine officer or an environmental health officer a contravention of this Act by another person, or the reasonable likelihood of such a contravention, may request that their identity, and any information that could reasonably reveal their identity, not be disclosed to their employer or the other person.
>
> (2) Subject to any other Act of Parliament, no person shall disclose or permit the disclosure of that identity or information unless authorized in writing by the person who made the request.
>
> (3) Despite any other Act of Parliament, no person shall dismiss, suspend, demote, discipline, deny a benefit of employment to, harass or otherwise disadvantage a person for having
>
> a) made a report under subsection (1);
>
> b) refused or stated an intention of refusing to do anything that they believed on reasonable grounds was or would be a contravention under this Act; or

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4(2) An employee of health care service provider may disclose to the Commissioner information that is obtained in the course of his or her employment and that the employee is otherwise required to keep confidential, for either or both of the following purposes:

> To seek advice about the employee's rights and obligations;
>
> To allow the information to be made public, if the employee believes that it may be in the public interest to do so.

Subsection 4(5) provides:

> No provider of health care services or person acting on behalf of such a provider shall take adverse employment action against an employee because the employee has, acting in good faith, disclosed information under subsection (2).

[227] Bill 22 was first introduced as private members in Bill 50, 1998, in the 2nd Session of the 36th Parliament by Marion Boyd. Bill 22 remains essentially the same as drafted under Ms. Boyd's direction with two additions noted by Ms. Martel in 2002, in the 3rd Session 33rd Parliament, in debate and second reading. It has been referred to the Committee of the Whole House once under Ms. Boyd and once under Ms. Martel but was never debated and died.

> c) done or stated an intention to do anything that they believed on reasonable grounds was required under this Act.

The other recent piece of federal legislation is Bill C-11, titled *"An Act to establish a procedure for the disclosure of wrongdoings in the public sector, including the protection of persons who disclose the wrongdoings."*[228] It mandates the establishment of a process by which public sector employees can report wrongdoings in the public sector. Section 19 prohibits reprisals against public servants who make disclosures in accordance with the Act. The protection, however, is limited to federal public sector employees.

Recently, the Justice Policy Committee, examining emergency management law in Ontario, made the following recommendation in respect of whistleblower protection:

> Preventing the spread of communicable diseases such as SARS, and ensuring a proper response by the public health system requires open communication between those on the front line, hospital administrators, and government representatives. Sec. 95(4) of the *Health Protection and Promotion Act* protects employees who report occurrences of communicable or reportable diseases, but does not protect, for example, individuals who raise concerns about how disease is being addressed by the public health system.
>
> 14. The Committee recommends that government protect employees who, in good faith, raise concerns about public health and other emergency risks by codifying whistleblower protection.[229]

Principles of Whistleblower Protection

Enough has been said to demonstrate the wide range of current whistleblower provisions and proposals which exist federally and in Ontario. A similarly wide range of legislation exists in other countries.[230] The form of protection depends on its purpose. Some whistleblower statutes have as their purpose the public exposure and prosecution of the employer. These statutes focus on wrongdoing and punishment. However, the object of public health whistleblower protection is not to punish but to protect the public's health by ensuring timely investigation of a public health risk.

The structure of public health whistleblower protection would be necessarily different from the provincial workplace safety provision and the federal environmental provisions. The latter statutes deal largely with disclosure for the purpose of enforcement or prosecution, while public health disclosure is encouraged for the purpose of investigation and correction.

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[228] Bill C-11 received first reading on October 8, 2004.

[229] Legislative Assembly, Standing Committee on Justice Policy, "Report on the Review of Emergency Management Law in Ontario," November 2004, p. 7.

[230] Three Whistleblower Protection Models: A Comparative Analysis of Whistleblower Legislation in Australia, the United States and the United Kingdom, Sheryl Groeneweg, Research Directorate, Public Service Commission of Canada, October 2001.

Another unique feature of health care worker whistleblowing is the private and confidential health information about individual patients that might necessarily be involved in the disclosure to a medical officer of health of a public health danger.

It is beyond the Commission's mandate to debate the question of whether there should be some form of general whistleblower protection throughout the health care system, or indeed the government in general. The Commission's mandate is limited to the public health issues raised by SARS.

The Commission proposes a strong and simple form of protection based on the need to protect employees and encourage the speedy investigation and resolution of public health risks without focusing on wrongdoing or prosecution. The Commission's proposal consists of a clear prohibition against whistleblower retaliation and requires no administrative machinery.

SARS demonstrated that an infection control problem in one hospital can quickly become a problem for the entire province. It must be ensured that any problem in any health care facility that creates a public health hazard is brought to the attention of the medical officer of health or Chief Medical Officer of Health. Otherwise such problems can simmer within a health care institution, uninvestigated and unknown to the authorities, and then break out into the community suddenly and without warning.

The elements of the proposed protection are:

- It applies to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;
- It enables disclosure to a medical officer of health (including the Chief Medical Officer of Health);
- It includes disclosure to the medical officer of health (including the Chief Medical Officer of Health) of confidential personal health information;
- It applies to the risk of spread of an infectious disease and to failures to conform to the *Health Protection and Promotion Act*;
- It prohibits any form of reprisal, retaliation or adverse employment consequences direct or indirect;[231]

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[231] Although specific types of reprisal could be listed, as in Ontario's workplace legislation, the listing of specific examples can shift the focus from the strong general prohibition to any gaps in the examples that can be found by an ingenious lawyer or administrator. It is therefore recommended that the prohibition remain general.

- It requires only good faith on the part of the employee; and
- There is both a punitive and a remedial penalty attached to the protection.

The protection should apply to a broad category of people, from nurses, to doctors, to porters, clerks and cleaning staff. It should apply to anyone who employs or engages the services of a health care worker, whether they be permanent staff, contract staff, full-time staff, or part-time casual staff. Each and every health care worker in the province must be assured an equal level of protection, regardless of location of employment or their employment status.

The Commission recommends that the whistleblowing be permitted to the local medical officer of health or the Chief Medical Officer of Health. Some have recommended to the Commission that the whistleblower provisions must include the power to allow a health care worker to whistleblow publicly. For example, OPSEU, in their submission to the Commission, stated:

> Indeed, we suggest that this protection be augmented. The *Environmental Bill of Rights* provision does not include protection for providing information to the public. This shortcoming is of particular importance in circumstances where the employee of an enforcement agency is raising a concern that the enforcement agency itself is not performing its duties appropriately. In those circumstances, the only practical alternative for that employee may be to provide the information to the public or to the political process for review. There should be protection for doing so.

The extension of whistleblower protection into the political and media arena would add an entirely new layer to the proposed system of disclosure to the Chief Medical Officer of Health or the medical officer of health. Such extension would require a separate system of safeguards to guarantee that disclosure could not bring confidential personal health information directly or indirectly to the public domain.

It is not clear at this time that anything is required beyond confidential disclosure to the Chief Medical Officer of Health or a medical officer of health who are protected from political interference and armed with the fullest independent authority to investigate and to intervene and speak out publicly[232] without fear of employment consequences. The proposed system of protected disclosure to the Chief Medical Officer of Health or a medical officer of health should be given a chance to work before building an extra layer on the speculation that the proposed system will not work. Until the proposed system has been given a chance to work, the proposal for media and public disclosure is not ripe for enactment.

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[232] As noted above, the government has increased the independence of the Chief Medical Officer of Health. This report recommends further measures of independence for the Chief Medical Officer of Health and local medical officers of health.

The Commission recommends that this whistleblower protection described above, be included in the *Health Protection and Promotion Act* and that it extend to all disclosures made in relation to the risk of spread of infectious disease and/or violations of the *Health Protection and Promotion Act*. It would thus become an integral part of the public health protection system administered by the medical officer of health and the Chief Medical Officer of Health.

For three reasons, the Commission recommends that the disclosure be tied directly to the risk of the spread of infectious disease and/or violations of the *Health Protection and Promotion Act*.

The first reason is that other health system problems, such as patient treatment generally, patient safety, occupational health and safety and other general health issues, are outside the direct responsibility of the Chief Medical Officer of Health and the medical officer of health. They cannot, with their enormous range of duties and limited resources, be expected to solve all the problems of the health care system. As one expert commented to the Commission:

> … the push will come that it … needs to be universal. If I see a patient maltreated, I want to be able to report; I do not care if it is a public health issue or not … The worst-case scenario is it gets broadened, broadened, broadened and the medical officers of health become the arbiters of every problem in the health system.

The second reason is that to encourage health care workers to report to the medical officers of health problems unrelated to their own duties and resources is to create unrealistic expectations on the part of the public as to the limited role of the medical officers of health and their inability to solve all problems. As another health expert cautioned:

> Keep in mind too, the medical officers of health are constrained by the Act itself. Their powers are set out in the Act, their ability to respond to whistle blowing is limited by the Act. So if they are getting a whole bunch of reports outside their mandate, it is true that they are not under any obligation to act. But it is going to create a fairly negative impression from members of the public if they are being asked to do things that are clearly outside their authority to do under the Act and they are going to get such pressure if there is no limit put on what sort of complaints can be brought forward to the medical officer of health as part of whistleblower protection.

To encourage workers to report a problem to an official who has no mandate or ability to deal with the problem is to mislead both the worker and the public.

The third reason is that other forms of disclosure relating to matters such as worker health and safety are already covered by existing legislation and governed by the machinery of other statutes such as the *Occupational Health and Safety Act*. Workplace health and safety issues arising from SARS are strongly on the Commission's agenda and will be dealt with in the final report. This interim report deals only with the public health aspects of whistleblower disclosure where health care workers have no protection at all. Whatever issues may be identified in the current legislation or in the role that the Ministry of Labour played during the SARS outbreak, the solution does not lie in forcing the medical officer of health to intervene in relation to issues outside their mandate, resources and legal powers.

The good faith requirement proposed by this Commission excludes from protection only those disclosures that are made for some bad faith purpose, such as personal malice. Some whistleblower legislation, by requiring "reasonable and probable grounds" instead of mere good faith, diminishes the protection afforded to the worker.

To require that the worker have "reasonable and probable grounds" to believe that the apprehended problem actually does exist in fact is a high hurdle for the health care worker, akin to the criminal requirement that a police officer, before laying a criminal charge, must have objective reasonable and probable grounds to believe that a criminal offence has been committed. There are lower thresholds such as "reasonable suspicion" and "reason to believe." A requirement of "reasonable and probable grounds" or even "reasonable suspicion" attracts the criminal standard and it could lead to endless arguments in court about the degree of proof required before a health care worker can disclose a problem. This criminal law baggage is an unecessary burden for the health care worker who sees a potential infection control problem or a cluster of uninvestigated suspicious infections and simply wants to make sure that someone looks into it.

It is important to ensure that the whistleblower protection does not put the threshold too high for effective health care worker protection. The Commission recommends that the worker be protected so long as the disclosure is made in good faith. In recommending the good faith requirement the Commission rejects the "reasonable and probable grounds"[233] requirement that would afford too little protection to the worker.

Finally, the protection must come with penalties for violation, both punitive and remedial. For example, paragraph 70(1)(a) of the *Personal Health Information Protection Act*, makes it an offence for anyone to dismiss, suspend, demote, discipline, harass or otherwise disadvantage a person who has made a report or complaint to the Commissioner under the Act.[234] Such a

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[233] The *Public Interest Disclosure Act*, 1998 (U.K.), 43B(2) of the United Kingdom:

> to qualify for protection, requires that the worker making the disclosure must be acting in good faith throughout and must have reasonable grounds for believing that the information disclosed indicates the existence of one of the defined problems.

[234] Subsection 70(1) provides:

> No one shall dismiss, suspend, demote, discipline, harass or otherwise disadvantage a person by reason that,
>
> (a) the person, acting in good faith and on the basis of reasonable belief, has disclosed to the Commissioner that any other person has contravened or is about to contravene a provision of this Act or its regulations;
>
> Subsection 72(1) provides:
>
> A person is guilty of an offence if the person,

violation is punishable by a fine of up to $50,000.00 where the offender is a natural person and $250,000.00 where the offender is not a natural person.[235]

While these deterrent penalties are essential, remedial protection is equally important. It is not enough to punish the employer if the employee is left without any remedy. It is of little assistance to the health care worker if the violating employer is fined but the worker is left without a job. Other statutes, such as the *Environmental Bill of Rights*[236] and the *Occupational*

(j) contravenes section 70.

[235] Subsection 72(2) provides:

A person who is guilty of an offence under subsection (1) is liable, on conviction,

(a) if the person is a natural person, to a fine of not more than $50,000; and

(b) if the person is not a natural person, to a fine of not more than $250,000.

[236] Subsection 105(1) provides:

Any person may file a written complaint with the Board alleging that an employer has taken reprisals against an employee on a prohibited ground.

Reprisals

(2) For the purposes of this Part, an employer has taken reprisals against an employee if the employer has dismissed, disciplined, penalized, coerced, intimidated or harassed, or attempted to coerce, intimidate or harass, the employee.

Prohibited grounds

(3) For the purposes of this Part, an employer has taken reprisals on a prohibited ground if the employer has taken reprisals because the employee in good faith did or may do any of the following:

1. Participate in decision-making about a ministry statement of environmental values, a policy, an Act, a regulation or an instrument as provided in Part II.

2. Apply for a review under Part IV.

3. Apply for an investigation under Part V.

4. Comply with or seek the enforcement of a prescribed Act, regulation or instrument.

5. Give information to an appropriate authority for the purposes of an investigation, review or hearing related to a prescribed policy, Act, regulation or instrument.

6. Give evidence in a proceeding under this Act or under a prescribed Act.

Labour relations officer, authorization

106. The Board may authorize a labour relations officer to inquire into a complaint.

Labour relations officer, inquiry into complaint

Health and Safety Act,[237] have attempted to address this issue by establishing procedures for review by the Ontario Labour Relations Board, in cases of dismissal or workplace reprisals

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> 107. A labour relations officer authorized to inquire into a complaint shall make the inquiry as soon as reasonably possible, shall endeavour to effect a settlement of the matter complained of and shall report the results of the inquiry and endeavours to the Board.

Inquiry by the Board

> 108. If a labour relations officer is unable to effect a settlement of the matter complained of, or if the Board in its discretion dispenses with an inquiry by a labour relations officer, the Board may inquire into the complaint.

Burden of proof

> 109. In an inquiry under section 108, the onus is on the employer to prove that the employer did not take reprisals on a prohibited ground.

Determination by the Board

> 110. If the Board, after inquiring into the complaint, is satisfied that the employer has taken reprisals on a prohibited ground, the Board shall determine what, if anything, the employer shall do or refrain from doing about the reprisals.

Same

> (2) A determination under subsection (1) may include, but is not limited to, one or more of,
>
> (a) an order directing the employer to cease doing the Act or acts complained of;
>
> (b) an order directing the employer to rectify the Act or acts complained of; or
>
> (c) an order directing the employer to reinstate in employment or hire the employee, with or without compensation, or to compensate instead of hiring or reinstatement for loss of earnings or other employment benefits in an amount assessed by the Board against the employer.

[237] Subsection 50(1) provides:

No employer or person acting on behalf of an employer shall,

(a) dismiss or threaten to dismiss a worker;

(b) discipline or suspend or threaten to discipline or suspend a worker;

(c) impose any penalty upon a worker; or

(d) intimidate or coerce a worker,

because the worker has acted in compliance with this Act or the regulations or an order made thereunder, has sought the enforcement of this Act or the regulations or has given evidence in a proceeding in respect of the enforcement of this Act or the regulations or in an inquest under the *Coroners Act*.

Arbitration

> (2) Where a worker complains that an employer or person acting on behalf of an employer has contravened subsection (1), the worker may either have the matter dealt with by final and binding settlement by arbitration under a collective agreement, if any, or file a complaint with the Board in

against a whistleblowing employee. In both statutes the burden of proof is on the employer to establish that it did not take repraisals on the prohibited ground. Health care workers who whistleblow for the protection of the public's health require protection equal to that afforded by the *Environmental Protection Act* and the *Occupational Health and Safety Act.*

The Commission therefore recommends that an employer who breaches the whistleblower protection is liable to a fine of up to $50,000.00 where the offender is a natural person and $250,000.00 where the offender is not a natural person, and that remedial machinery be enacted to restore a whistleblower to the position he or she held before the unlawful reprisal.[238]

> which case any rules governing the practice and procedure of the Board apply with all necessary modifications to the complaint.

Inquiry by Board

> (3) The Board may inquire into any complaint filed under subsection (2) and section 96 of the *Labour Relations Act, 1995*, except subsection (5), applies with all necessary modifications as if such section, except subsection (5), is enacted in and forms part of this Act.

Same

> (4) On an inquiry by the Board into a complaint filed under subsection (2), sections 110, 111, 114 and 116 of the *Labour Relations Act, 1995* apply with all necessary modifications.

Onus of proof

> (5) On an inquiry by the Board into a complaint filed under subsection (2), the burden of proof that an employer or person acting on behalf of an employer did not act contrary to subsection (1) lies upon the employer or the person acting on behalf of the employer.

Jurisdiction when complaint by Crown employee

> (6) The Board shall exercise jurisdiction under this section on a complaint by a Crown employee that the Crown has contravened subsection (1).

Board may substitute penalty

> (7) Where on an inquiry by the Board into a complaint filed under subsection (2), the Board determines that a worker has been discharged or otherwise disciplined by an employer for cause and the contract of employment or the collective agreement, as the case may be, does not contain a specific penalty for the infraction, the Board may substitute such other penalty for the discharge or discipline as to the Board seems just and reasonable in all the circumstances.

[238] The liability and penalty should be the same as that in the *Personal Health Information Protection Act*, including liability of officers and other employees as set out in s. 72(3). It provides:

> 72(3) If a corporation commits an offence under this Act, every officer, member, employee or other agent of the corporation who authorized the offence, or who had the authority to prevent the offence from being committed but knowingly refrained from doing so, is a party to and guilty of the offence and is liable, on conviction, to the penalty for the offence, whether or not the corporation has been prosecuted or convicted.

It should also include liability of directors.

Conclusion

Any health care worker should be free to alert public health authorities to a situation that involves the risk of spreading an infectious disease, or a failure to comply with the *Health Protection and Promotion Act*. Public health officials do not have the resources to be present in every health care facility at every moment. While one would expect that a facility administrator, infection control specialist, or practitioner would report to public health officials situations or cases that might risk the public's health, the cost of nonreporting or inaction is too high. In the event of such a failure to report, regardless of its cause, it is not enough to hope that public health officials will stumble across the problem eventually. SARS and other diseases[239] clearly demonstrate the importance of timely reporting of a risk to public health. Health care workers can be the eyes and ears of public health and the front line protectors of the public's health. They must be free to communicate with public health officials without fear of employment consequences or reprisals.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to provide health care workers whistleblower protection in accordance with the following principles:**
    - **It applies to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;**
    - **It enables disclosure to a medical officer of health (including the Chief Medical Officer of Health);**
    - **It includes disclosure to the medical officer of health (including the Chief Medical Officer of Health) of confidential personal health information;**
    - **It applies to the risk of spread of an infectious disease and to failures to conform to the *Health Protection and Promotion Act*;**
    - **It prohibits any form of reprisal, retaliation or adverse employment consequences direct or indirect;**[240]

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[239] For example, Tuberculosis. Consider the case of the delayed reporting of a homeless man with tuberculosis, which is discussed earlier in the "Reporting Requirements" chapter.

[240] Although specific types of reprisal could be listed, as in Ontario's workplace legislation, the listing of specific examples can shift the focus from the strong general prohibition to any gaps in the examples that can

- **It requires only good faith on the part of the employee; and**
- **It not only punishes the violating employer but also provides a remedy for the employee.**[241]

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be found by an ingenious lawyer or administrator. It is therefore recommended that the prohibition remain general.

[241] As noted above, the punishment recommended for an employer who violates the protection is a fine of up to $50,000.00 where the employer is a natural person and $250,000.00 where the employer is not a natural person.

8. Quarantine

Introduction

Quarantine and isolation are essential defences against infectious disease outbreaks. Public health officials must have the power to isolate those who are infected and to quarantine those who may have been exposed to infection and may be infectious to others.[242]

It is a great tribute to health care workers and the public that virtually all the quarantine and isolation during SARS took place voluntarily. Many thousands of people were quarantined in the greater Toronto area, enduring 10 days or more of home isolation.

It was necessary in only a handful of cases to resort to formal orders under the *Health Protection and Promotion Act*. Only 27 orders were issued in Toronto. It is a heartening demonstration of public cooperation, and a remarkable tribute to the public spirit of so many people, that so few formal orders were necessary.

The remarkable story of those who suffered quarantine without complaint will be told in the Commission's final report which will also address a number of concerns expressed about the administration of the quarantine powers. This interim report on legislative change will examine the legal machinery of quarantine in light of SARS and recommend some amendments to the *Health Protection and Promotion Act.*

Public Cooperation

Before turning to legal powers it must be emphasized that any fight against infectious disease depends above all on public cooperation. Without public cooperation, laws are little help.

SARS revealed an enormous spirit of public cooperation that has drawn the attention of foreign researchers. Of note are the findings of a major U.S. study of quarantine in Toronto that drew on a comprehensive series of interviews, telephone polls and focus groups. It concluded that civic duty, not fear of legal consequences, was the main motivator for those who observed quarantine:

> Overall, 94% of the 195 quarantined health care workers in our Health Care Workers Survey said that the most important reason for complying was to reduce the risk of transmission to others. This was the principal motivation among non-health care workers as well; "protection of the health of the community" was cited by 50 of 68 general population poll respondents who were directly affected by quarantine, and the majority of interviewees and focus group participants cast this motivation as "civic duty."

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[242] The word "quarantine" has a technical legal meaning quite different from the ordinary meaning understood by everyone during SARS. This is discussed below.

> In general, fear of running afoul of the law played little role in compliance. None of the 68 General Population Survey respondents who were directly affected by quarantine said that their most important reason for complying was to avoid enforcement measures and penalties, and 24 of 30 respondents who had been quarantined and were aware of the penalties said that their knowledge of these penalties did not affect their decision to comply.[243]

What generated this remarkable level of civic duty? According to this U.S. study, some distinctive elements of Canadian society, including publicly funded health care, likely helped to promote high levels of quarantine compliance:

> With the bulk of the Toronto SARS outbreak contained primarily in its health care facilities and among its health care workers, a centralized health care system (including employee pay and benefits) offered some advantages. These unifying aspects will not be in place in societies that rely heavily on private health care. Finally, while the overall quarantine compliance rate among residents of the GTA appears to have been high, the influence of "civic duty" and social responsibility may not be as significant in other countries and cultures.[244]

Added one expert from the Centers for Disease Control and Prevention in an interview with the Commission:

> I really believe you were the model. It may not feel that way inside your silo, but you really did move boldly and swiftly. We are all forever grateful for that fact that when you did this, you treated your Canadian citizens with dignity and respect and a lot of people are starting to write on this in academia … The way you proceeded appeared to be transparent. It appeared to be open and I think it worked. The data is stunning. The data that the Toronto health people, Dr. Barbara Yaffe and Jane Speakman, present … We all know about civil liberties and the aggressive advocacy-driven U.S. civil liability system and the civil liberties ship that launched itself in 1954 in this country, we believed that there would be a much more hostile perception to quarantine. And so seeing your data is stunning. Why did it go so well?

Laws are only the last resort. Legal procedures are useless without overwhelming public cooperation of the kind demonstrated in SARS. While it is important to strengthen the legal machinery available to public health officials, it is even more important to strengthen the things that encourage public cooperation. It is essential to ensure that the spirit of cooperation shown during SARS is not taken for granted. It must be nurtured and promoted using the lessons learned from SARS as a guide.

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[243] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, p. 267.

[244] *Ibid*, p. 271.

Public cooperation depends on public confidence that public health decisions are made on an independent medical basis with the single-minded goal of protecting the public from infectious disease. Any perception that decisions are made for political or economic reasons will sap public confidence and diminish public cooperation. That is why it is so important to have the Chief Medical Officer of Health, with the assistance where necessary of other public officials, actually and visibly in charge of any public health emergency.

Public cooperation depends on public understanding of what is necessary and on public trust that the authorities are keeping everyone informed of what is happening. Dr. Garry Humphreys, Medical Officer of Health for Peterborough County and City, said at the Commission's public hearings:

> It is important to have a willing cooperation of the community with regards to disease control through voluntary quarantine. This can only be achieved when the community is continuously kept informed.[245]

To that end, as recommended in the Commission's first interim report and repeated here, it is vital that an independent Chief Medical Officer of Health be front and centre in informing the public about important health issues like SARS. This avoids the perception of political interference and bureaucratic turmoil, fosters the trust between the public and those managing, and strengthens the community confidence so vital to the effective management of a public health emergency.

It is also vital that the public trust the judgment and expertise of the Chief Medical Officer of Health. The public will not follow an expert, no matter how much power he or she has, unless they trust both their motives and their abilities. This reinforces the need to enhance the Public Health Division to provide the Chief Medical Officer of Health with the best expert support and resources to make the right decisions, at the right times.

Compensation

In any emergency it is essential to compensate those who suffer an unfair burden of personal cost by reason of their cooperation with public health measures like quarantine.

While Ontario enjoyed high levels of quarantine compliance, it is vital that this not lead to complacency. SARS also revealed obstacles to compliance that may, if not adequately addressed, hamper the response to a future public health emergency, an influenza pandemic. In its interviews, telephone polls and focus groups, the U.S. study identified the following impediments to observance:

- Fear of loss of income;
- Poor logistical support;

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[245] SARS Public Hearings, October 1, 2003, p. 17.

- Psychological stress;
- Spotty monitoring of compliance;
- Inconsistencies in the application of quarantine measures between various jurisdictions; and
- Problems with public communications.[246]

Fear of loss of income topped the list of concerns:

> Fear of loss of income was of paramount importance. It was especially significant, according to our interviews, focus groups, and Health Care Workers Survey, for people who were unconvinced that their quarantine was necessary. This fear was the most common reason given to us for noncompliance or non-self-quarantine among people who were advised that they met quarantine criteria. And the fear was justified. Although some employers assured their employees at the outset that their pay would continue while they were in quarantine, others said it would not. The situation was even more disconcerting for those whose income came from part-time work, casual work, or self-employment.[247]

The federal and provincial governments provided a number of SARS compensation programmes.

On April 4, 2003, the federal government amended Employment Insurance regulations to make it easier for eligible workers to access EI benefits. A government news release stated:

> The amendments remove the usual two-week waiting period for SARS-related cases. The requirement for a medical certificate will also be removed when the period involved is the SARS-related quarantine (currently 10 days).
>
> The amended regulations apply to any SARS-related claims for EI sickness benefits where the period of quarantine has been imposed or recommended on the claimant by a public health official and the claimant was asked by the employer, a medical doctor, a nurse or another person in authority to quarantine himself/herself.[248]

On May 2, 2003, the federal government announced an income relief programme for health care workers who were not eligible for Employment Insurance but who suffered a loss of employment income because of being quarantined, isolated or contracting SARS. A government news release said:

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[246] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, pp. 267-70.

[247] *Ibid*, pp. 267-68.

[248] HRDC, "Changes to EI Regulations related to Severe Acute Respiratory Syndrome (SARS)," April 4, 2003.

> Weekly payments will be $400 per week for full-time workers, and $200 per week for part-time workers. A full-time worker is defined as a person who works the number of hours, days or shifts normally worked in a calendar week by a full-time worker in the same or similar occupation, and at the same or similar premises. A part-time worker is defined as a person who does not work full-time as described above. Eligible recipients will be able to receive a maximum of $6,000 for a maximum period of 15 weeks. The program is retroactive to March 30, 2003.[249]

On May 28, 2003, the Government of Ontario announced financial aid for health care workers for income lost due to SARS. A government news release stated:

> Eligible health care employees and physicians will be reimbursed for income lost due to SARS. This financial aid is expected to total up to $190 million.[250]

On June 13, 2003, the Ontario government announced a compensation programme for individuals who were sick, isolated or gave care to someone directly affected by SARS, but who did not receive full pay from their workplace or from other sources. The programme provided an isolation payment of $500 for full-time employees and $250 for part-time employees. Those whose losses were greater could apply for more compensation. So could those who received partial payments from other sources. The maximum amount was $6,000. A government news release said:

> This program is open to employed and self-employed Ontario residents who lost income because they were isolated, sick with SARS, or gave care to someone directly affected by SARS for at least five days between March 14 and June 30, 2003. Individuals who received full pay from their workplace or from other sources for the time they were off work are not eligible for this program.
>
> Individuals who received no income or benefits from their employer or other sources may be eligible for an isolation payment of $500 (part-timers are eligible for a $250 isolation payment.) Those whose losses were greater than the isolation payment can apply for more assistance. Applicants will be required to submit appropriate documentation to support their claim and consent to the verification of information.

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[249] HRDC, "Government of Canada provides income relief to SARS affected health care workers," May 2, 2003.

[250] Canada News Wire, "Eves government provides $720 million in SARS assistance for health care workers, facilities and emergency services," May 28, 2003.

> Those who received partial payment for the time they were in isolation may also be eligible. Any financial assistance provided by other sources will be deducted from the total claim e.g. Employment Insurance payment etc. Full documentation of losses is required with every claim. If any of the information is found to be untrue, appropriate action will be taken to recover any amounts already paid through the program.
>
> The maximum amount of assistance under this programme is $6,000. Full programme details are available with the application forms. For those who were ill or isolated and are in extreme, immediate financial hardship, help is available.[251]

The Ontario SARS compensation programme was designed, as one government official put it,

> … for people who had been quarantined and so have lost wages; they could come forward and claim two thousand dollars I think and five thousand dollars for health care workers … It was a recognition that these people had obeyed a request and had suffered a loss because of it. We wanted to recognize … and thank them for fulfilling their obligations as citizens, because these were people who were not even under a court order. It was just a request … to stay home for 10 days.

Compensation packages, were not implemented until well into the outbreak. The impression also may have been created, whether intended or not, on April 16, 2003, that provincial compensation efforts would be limited.[252] Less than a week later, the government announced that workers would be reimbursed for any lost income as a result of being in quarantine. Premier Ernie Eves said:

> "I am giving you my word that any Ontarian who has lost wages because they've been asked to go into quarantine by public health officials will be fully compensated," Eves said as he took the unusual step of attending the daily SARS briefing held by health officials.
>
> "People will not have to choose between doing the right thing and putting food on their table."[253]

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[251] Canada News Wire, "Eves government acts to compensate people affected by SARS," June 13, 2003.

[252] An April 16, 2003, report on the CBC stated: "Ontario Premier Ernie Eves says governments can't afford to compensate every person or business affected by SARS … [Eves] warned that governments can't afford widespread compensation for the economic impact of SARS. 'If we start to write cheques to every single individual that has any economic impact as a result of SARS you can see what the result would be. The bill would be tens of billions, perhaps even more than that,' said Eves." (Source: CBC, "Eves considers tax relief for SARS losses," 16 April 2003).

[253] Canadian Press, "Ontario to compensate those quarantined by SARS," April 25, 2003.

As noted in the U.S. study referred to above:

> The provincial government's initial approach did not assuage these concerns. There were no plans in place that could provide assistance to those in quarantine, and when the issue was raised, the provincial premier dismissed compensation packages as being unfeasible. In addition, the province's Workplace Safety and Insurance Board, which administers the workers' compensation system, announced that only those who developed symptoms of SARS and were infected at work would be eligible for compensation. This meant that the vast majority of those in quarantine would not receive workers' compensation for their time away from work. On April 24, the premier reversed his position on compensation and said, "People will not have to choose between doing the right thing and putting food on the table." This new position, however, was not accompanied by any immediate, concrete action.
>
> Compensation was not addressed until May 27, when the province announced a C$190 million compensation package for health care workers who had lost wages due to SARS. It was not until June 13 that a similar "compensation allowance" was announced for non-health care workers who had missed work due to quarantine or caring for someone else in quarantine.[254]

Despite criticism that it took too long to bring forward an appropriate compensation package, some observers suggest that the compensation system, once in place, was largely responsible for the success of the voluntary quarantine programme. Dr. James Young has said that compensation for those quarantined was a vital element of Ontario's response to SARS:

> During SARS, we were using quarantine for the first time in 50 years. One of the important things in using quarantine was getting people to abide by it. One of the important ways of getting people to abide by it was by offering financial compensation so they would in fact abide by it and stay in quarantine if and when they were ordered by the medical officer of health. We got approval from the Ontario government to institute a quarantine program and to pay people for that. That resulted in us being able to manage the quarantine in an effective manner.[255]

The message is that it is important to plan in advance for the compensation of those whose cooperation in the emergency effort is so vital. It is impossible to predict in advance exactly what form and level of compensation is necessary and affordable for every conceivable emergency. But it is possible to require by legislation that every government emergency plan include a basic blueprint for the most predictable types of compensation packages. And it is possible to legislate that compensation, in a form and amount to be decided by the government.

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[254] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, p. 268.

[255] Justice Policy Committee, Public Hearings, August 3, 2004, p. 10.

Recommendation

The Commission therefore recommends that:

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

Adequate Support Systems

Public confidence also requires that those who make personal sacrifices by isolating themselves from their friends and family get adequate support from the system that restricts their freedom. Whatever legal authority there is for quarantine, it will only work if emergency response plans provide adequate and timely information and support.

The U.S. study noted:

> Communications to the public from the government regarding quarantine's concept, rationale, and rules received mixed reviews in our polls, focus groups, and interviews and in the government's own assessment. Challenges arose from the lack of information about the new disease of SARS and the uncertainties of its future course. Another source of confusion was inconsistency in the definitions of "probable cases," "suspect cases," and "cases under investigation" employed by public health officials and the World Health Organization. For example, on May 28, 2003, at the beginning of the second SARS outbreak in Toronto, an official reported the total number of probable SARS cases in the Toronto area as 11; but, under questioning, another senior public health official revealed that the real number was somewhere between 23 and 48. In addition, the tendency of the media to report cumulative cases of SARS rather than changes in the number of new cases gave the appearance that the outbreak was spiraling higher when in fact it was ebbing. Another major problem involved the government's use of the term "voluntary quarantine," because it suggested that compliance was at the discretion of each person. Officials told us they initially believed that people would be more willing to comply and less likely

> to "panic" with use of the adjective "voluntary," but, in retrospect, they realized they should have avoided that word.[256]

Many of those interviewed by the Commission who were placed in quarantine raised concerns about the lack of information and support. Hawryluck[257] made similar findings in their survey of 129 quarantined individuals[258]:

> During the outbreak, nearly 30% of respondents thought that they had received inadequate information about SARS. With respect to information regarding home infection control measures, 20% were not told with whom they could have contact; 29% did not receive specific instructions on the use and disinfection of personal items, including toothbrushes and cutlery, 77% were not given instructions regarding the use and disinfection of the telephone.[259]

The Hawryluck study also found:

> Those who did not think that they had been well-informed were angry that information on infection control measures and quarantine was inconsistent and incomplete, frustrated that employers (health care institutions) and public health officials were difficult to contact, disappointed that they did not receive the support they expected, and anxious about the lack of information on the modes of transmission and prognosis of SARS.

This is not to criticize the remarkable work done by overworked public health workers struggling to cope without a plan, without preparation, and without adequate resources. The problems were systemic, not personal or professional.

The U.S. study found that the stigma of quarantine persisted for many people long after they had left quarantine:

> Being the target of stigma was reported by 17 of the 43 quarantined persons in our General Population Survey, and 68% of the 195 quarantined health

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[256] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, p. 269.

[257] Hawryluck L, Gold WL, Robinson S, Pogorski S, Galea S, and Styra R. SARS control and psychological effects of quarantine, Toronto, Canada. Emerg Infect Dis [serial on the Internet]. 2004 Jul [date cited] Available from: http://www.cdc.gov/ncidod/EID/vol10no7/03-0703.html.

[258] Similar findings were cited by researchers in Toronto and New York, who conducted a web-based survey open to anyone who was quarantined during SARS in Toronto. A total of 129 individuals volunteered to participate.

[259] Hawryluck L, Gold WL, Robinson S, Pogorski S, Galea S, and Styra R. SARS control and psychological effects of quarantine, Toronto, Canada. Emerg Infect Dis [serial on the Internet]. 2004 Jul [date cited] Available from: http://www.cdc.gov/ncidod/EID/vol10no7/03-0703.html.

> care workers reported that stigma affected them or someone close to them. Focus group participants who were quarantined reported that they and their families often felt stigmatized, even after the 10-day period of quarantine ended. They reported unwanted attention, ridicule, avoidance, and withdrawn invitations from such social events as children's birthday parties and family reunions. Their children were unwelcome in some daycare centers, and some spouses of quarantined health care workers were sent home from work. Because of this treatment, participants said they became reluctant to tell others that they had been in quarantine.[260]

Whatever legal authority there is for quarantine, it will only work if emergency response plans provide the resources and machinery to help those who must go into quarantine.

The Commission heard countless stories of family members and neighbours providing the support necessary to enable those under quarantine to be compliant. As one woman under quarantine described the experience:

> Nobody worked. Nobody went to work, nobody went to the grocery store, nobody did anything. We had neighbours that were delivering groceries.

For those individuals with children at home, the hardship and stress of quarantine proved to be even more overwhelming. One health care worker with small children at home, described the hardship of quarantine:

> … you are completely detached from everybody, okay? I'm a single parent. I don't have anybody to get my groceries for me … So to be locked up 10 days in the house for me, with my kids. I have nobody to take care of them. I have nobody to bring me my groceries, I relied on the kindness of my friends time after time after time.

In one story told to the Commission, the need to ensure the well-being of a child clashed with the need to comply with quarantine. The woman's young child became ill while the mother was under quarantine. An ambulance was called and the child was taken to hospital. The mother, quarantined because of her previous exposure to SARS, was not allowed to go in the ambulance. Desperate with concern for her child she broke quarantine and followed the ambulance to hospital where she tried to gain admission, which was denied. While one can appreciate her concern and fear for her child, it might have had disastrous consequences had she entered the hospital and spread the infection there. This demonstrates the human problems that arise during quarantine and the need for sensitive yet firm enforcement of quarantine.

In another case a public health unit was placed in the difficult position of trying to find caregivers for two young children who exhibited no symptoms but whose father was in hospital with SARS. Although the mother was at home, she had a fever and her condition worsened. There was no one else to look after the children. By the time the mother had to be admitted to hospital the children were showing symptoms and all three were taken to hospital. This shows again the human problems that arise in the administration of quarantine.

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[260] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, p. 269.

Prior to SARS, widespread quarantine measures had not been used in more than 50 years.[261] For myriad reasons outlined in the Commission's first interim report, public health workers, by reason of systemic failure and no fault of their own, were ill-equipped and unprepared to deal with the vast number of individuals who were quarantined.

Despite these handicaps, public health officials rose to the occasion and deserve praise for their commendable efforts to address the problems caused by quarantine. In the case involving the two young children, for example, a public health physician, despite her other overwhelming duties, went to extraordinary lengths to find alternate caregivers. In another noteworthy instance, a public health unit went to great trouble to establish a contingency facility in case homeless individuals had to be quarantined. As noted in the Commission's first interim report, the problems in the administration of quarantine reflect a lack of planning and preparedness, not a lack of dedication or effort on the part of public health officials. As one expert from the Centers for Disease Control and Prevention remarked:

> I had seen those people from Canada and Toronto, Ontario and Health Canada speak at health forums in this country. And they all get a lump in their throat when they describe it. And it puts a lump in mine. They did a heroic job. And they're to be commended and this process that unfolds afterwards is something to be expected but they know, they know how we feel about them. They are our heroes and we all hope that when our number gets called, that we can do as good a job as they did. And we're trying to learn from those lessons.

The studies and stories of quarantine during SARS show above all that the legal power to quarantine comes with a concurrent responsibility to ensure that those in quarantine are given adequate support to enable and encourage them to comply with quarantine. This duty applies with particular force to the most vulnerable in our community including the homeless.

Necessary support may require a wide range of assistance including:

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[261] Severe acute respiratory syndrome (SARS) was contained globally by widespread quarantine measures, measures that had not been invoked to contain an infectious disease in North America for more than 50 years. Although quarantine has periodically been used for centuries to contain and control the spread of infectious diseases such as cholera and the plague with some success, the history of invoking quarantine measures is tarnished by threats, generalized fear, lack of understanding, discrimination, economic hardships, and rebellion Hawryluck L., Gold WL, Robinson S, Pogorski S, Galea S, and Styra R. SARS control and psychological effects of quarantine, Toronto, Canada. Emerg Infect Dis [serial on the Internet]. 2004 Jul [*date cited*]. Available from: http://www.cdc.gov/ncidod/EID/vol10no7/03-0703.html.

- delivery of groceries;
- refill and delivery of medication;
- ensuring that children are safely transported to and from daycare or school;
- taking care of children, people with special needs and the elderly whose primary caregivers have been quarantined;
- special quarantine contingencies for vulnerable populations, such as the homeless;
- ensuring that those under quarantine have an adequate supply of personal protective equipment.

As the U.S. study stated:

> Logistical support of those in quarantine was mostly handled privately, not through the government. Non-health care workers whom we interviewed or who participated in our focus groups praised public health authorities for delivering kits of medical supplies at the beginning of their quarantine periods. These kits contained thermometers (for twice-daily monitoring of body temperature), surgical masks, wipes, and similar items; health care workers obtained these supplies on their own or through their employers. It was a different story, however, for groceries and other routine supplies needed for daily living. With no prior planning for such large-scale deliveries and difficulties in coordination between local health departments and volunteer and service organizations, the government was unable to meet these needs. Internet grocery delivery services were widely used and well rated by those with access to computers at home, and some medical facilities established small grocery stores in their cafeterias for the benefit of their employees who were on "work quarantine." However, 83% of the quarantined health care workers in our survey said they relied on friends, relatives, or neighbors for groceries and supplies, and 4% said they broke quarantine to get them for themselves. Of 47 health care workers who said they needed to arrange for the transportation of someone in their household who normally would rely on them for transportation, such as children or a disabled or elderly relative, 39 relied on family or friends, but 6 had to leave quarantine to provide this service themselves. From our interviews and focus groups, it seemed that single people and students had greater difficulty in relying on or obtaining the assistance of others.[262]

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[262] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, pp. 268-9.

It is not suggested that government programmes should be designed to replace or supplant the great outpouring of private family and community support that helped so many people get through quarantine during SARS. It is suggested that the crucial nature of this support be publicly recognized and encouraged in every way possible.

There is also a need to secure access to support systems for those under quarantine who experience unusual stress. Many interviewed by the Commission spoke of the psychological stress of quarantine. One person, who lived alone, experienced weeks of agony during quarantine. She described to the Commission how she became increasingly depressed during quarantine, and how there was no support available for her to talk to or to ensure that she was mentally coping during her quarantine:

> … not once did they ask me if I had any thoughts of hurting myself; I threw out my Tylenol because I was afraid that I was going to take it … Could you image what [that many] days is like with no human contact with anyone? I understand that this is a contagious disease and you want to control it and they needed to control it but they also needed to understand that there is a mental health issue here with these people and I know that I am not the only one that got upset and depressed.

The Hawryluck quarantine study found that a substantial portion of the 129 respondents displayed symptoms of post-traumatic stress disorder.[263]

SARS made us aware not only of the need for quarantine to prevent the transmission of infectious diseases, but of the real human hardship caused by quarantine, and of the need for programmes to provide direct support and encourage private family and community support.

This conclusion is endorsed by Hawryluck:

> Public health officials, infectious disease physicians, and psychiatrists need to be aware of this issue [the psychological distress caused by quarantine]. They must work to define the factors that influence the success of quarantine and infection control practices for both disease containment and community recovery and must be prepared to offer additional support to persons who are at increased risk for the adverse psychological and social consequences of quarantine.[264]

Public health staff alone cannot bear the responsibility for meeting these demands. Employers, educators, community groups, businesses, emergency responders, hospitals and public health must plan together to ensure that those quarantined in the future have timely and adequate information and the support necessary to encourage and enable them to comply with quarantine.

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[263] *Ibid.*

[264] *Ibid.*

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to provide that it is a mandatory public health standard for each local medical officer of health to develop under the guidance of the Chief Medical Officer of Health a local plan in consultation with employers, educators, community groups, businesses, emergency responders, and health care facilities to ensure that plans are in place to ensure that those quarantined in the future have timely and adequate information, and the support necessary to encourage and enable them to comply with quarantine.**

Job Security

By the same token, those who are ordered into quarantine should not have to worry about job security. This concern was raised by a number of those who spoke to the Commission, and was also discussed during the Standing Committee on Justice Policy hearings:

> Ms. Broten: One very quick, last question. We also heard that during SARS one of the barriers of keeping individuals safe and in their homes or under quarantine was the concern they would lose their jobs because there was no job-protected quarantine leave or what have you—I see everyone nodding. If someone just wanted to comment as to whether that was a reality you faced out on the front lines.
>
> Dr. Henry: Early on, it was a very difficult problem. Businesses were reluctant to let their people stay home. We wrote a number of very stern letters suggesting to them that the risk to their business if this person became ill in the workplace might outweigh their reluctance to let this person stay home for the period of time we prescribed. I think being able to enact emergency financial assistance to people in a crisis is extremely important, and I don't believe there was the legislative ability to do that at the time.[265]

On April 30, 2003, the *SARS Assistance and Recovery Strategy Act* was introduced in the Ontario legislature. It received first, second and third reading that day and received Royal Assent on May 5, 2003. The Act addressed a number of issues, including the problem outlined above of people who feared losing their employment as a consequence of quarantine or illness during SARS. Section 6(1) provides that a person was entitled to a leave of absence without pay where he or she was unable to work as a result of investigation or treatment related to SARS or because they were subject to quarantine or isolation.[266] The section also protects those who were unable to work because they were needed to provide care or assistance to a spouse, child, grandparent, sibling or relative who was dependent on the employee for care and assistance.

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[265] Justice Policy Committee, Public Hearings, August 18, 2004, p. 159.

The Act, while important, did little to alleviate the stress and uncertainty for those whose employment was threatened due to quarantine or illness prior to its enactment.

This is an important consideration in preparing for future health emergencies. Focus groups conducted for the above-noted U.S. study suggested that an important impediment to compliance is not knowing the precise details of compensation packages:

> Participants in our focus groups were asked the level of detail they would require about the compensation package as a condition for complying with "voluntary" quarantine. The general consensus was that a significant level of detail would be required, including the level of compensation, whether benefits would be included in the calculation of compensation, and the length of time that an individual would have to wait to receive compensation. When asked in our Health care Workers Survey, 60% of doctors, 76% of nurses, and 70% of other health care workers said that they would want "fairly detailed information about when, how, and how much compensation" they would receive as encouragement to comply with quarantine.[267]

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[266] Section 6 (1) provides:

> During the period beginning March 26, 2003 and ending on a day specified by proclamation of the Lieutenant Governor under subsection 1(2), an employee is entitled to a leave of absence without pay for any day or part of a day during which he or she falls into one or more of the following categories:
>
> 1. The employee is unable to work because he or she is under individual medical investigation, supervision or treatment related to SARS.
>
> 2. The employee is unable to work because he or she is acting in accordance with a SARS related order under section 22 or 35 of the Health Protection and Promotion Act.
>
> 3. Subject to subsections (2) to (4), the employee is unable to work because he or she is in quarantine or isolation or is subject to a control measure in accordance with SARS related information or directions issued to the public, a part of the public or one or more individuals, by the Commissioner of Public Security, a public health official, a physician or a nurse or by Telehealth Ontario, the Government of Ontario, the Government of Canada, a municipal council or a board of health, whether through print, electronic, broadcast or other means.
>
> 4. The employee is unable to work because of a direction given by his or her employer in response to a concern of the employer that the employee may expose other individuals in the workplace to SARS.
>
> 5. The employee is unable to work because he or she is needed to provide care or assistance to an individual referred to in subsection (5) because of a SARS related matter that concerns that individual.

[267] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, pp. 267-68.

One problem during SARS was that people worked while ill, a tendency exhibited by many hardworking Canadians. It is necessary to discourage anyone from attending work who displays symptoms of an infectious disease or who is required to be in quarantine as a result of contact with an infectious person. One only need consider the case of the Hewlett-Packard factory, where nearly 200 employees and visitors went into quarantine because an employee attended work while ill and under quarantine.[268] It is essential that educational, compensation, and enforcement programmes be planned in advance and put in place immediately to prevent this kind of problem.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to add a provision similar to s. 6(1) of the *SARS Assistance and Recovery Strategy Act*, to apply to infectious diseases as identified by the Chief Medical Officer of Health. The amendment should provide, in respect of such a disease, that a person is entitled to a leave of absence without pay where he or she is unable to work as a result of investigation or treatment related to the disease, or because he or she is subject to quarantine or isolation. The amendment should also protect those who are unable to work because they are needed to provide care or assistance to a spouse, child, grandparent, sibling or relative who is dependent on the employee for care and assistance.**

Monitoring of Compliance

It is hard to suffer the pangs of quarantine only to see a neighbour thumb his or her nose at a quarantine order. The perception that others are cheating can easily erode the commitment to voluntary compliance. The U.S. study found:

> Spotty monitoring of compliance produced incomplete rates of compliance and invited cheating. Public health authorities announced that they would telephone people in quarantine at home twice a day, at varying times, to monitor their compliance. That monitoring played "an important role in terms of establishing the credibility of quarantine in general," said 75% of the physicians in our Health care Workers Survey, 81% of the nurses, and 85% of the other health care workers. Yet, 58% of the physicians, 37% of the nurses, and 40% of the other workers rated the monitoring of their compliance while in quarantine as bad. When people wanted or needed to

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[268] CBC News, "Man Who Broke Quarantine May Face Charges," April 11, 2003; CBS, May 29 2003. A Hewlett-Packard employee near Toronto has died. The 62-year-old HP employee broke quarantine to go to work at the company's information processing plant in Markham, north of the Toronto, despite showing symptoms of SARS. Health authorities called for a quarantine of the HP plant last month when they learned the man could have knowingly placed nearly 200 co-workers in danger.

> break quarantine—for example, to get groceries—they said they did so with little fear of getting caught. The problem was that the large number of people in quarantine swamped the information technology capabilities, staff, and phone lines of the public health systems. Regions in the GTA with fewer people in quarantine were generally better able to increase their capabilities to carry out this monitoring, but the city of Toronto's public health department was overwhelmed.[269]

For these reasons it is important that the legal machinery be adequate to ensure the fair and uniform application of the quarantine system, including the ability to enforce quarantine orders against those few people who are disinclined to obey them. The very existence of quarantine laws, and the fairness of their application, reinforces the individual and community sense that voluntary compliance is the reasonable thing to do.

The present system under the *Health Protection and Promotion Act* has two basic elements.

1. A medical officer of health may make a written order requiring the isolation of someone who may have a communicable disease. This order is called a s. 22 order.[270]

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[269] Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, p. 268.

[270] Subsection 22(1) provides:

Order by MOH re: recommunicable disease

A medical officer of health, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease

Subsecton 22(4) provides:

What may be included in order,

(4) An order under this section may include, but is not limited to,

(a) requiring the owner or occupier of premises to close the premises or a specific part of the premises;

(b) requiring the placarding of premises to give notice of an order requiring the closing of the premises;

(c) requiring any person that the order states has or may have a communicable disease or is or may be infected with an agent of a communicable disease to isolate himself or herself and remain in isolation from other persons,

(d) requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order;

(e) requiring the destruction of the matter or thing specified in the order;

2. If a person refuses to comply with the order of the medical officer of health in respect of a virulent disease[271] a judge of the Ontario Court of Justice may order the person to be taken into custody and detained in a hospital or other facility. This order is called a s. 35 order.[272]

Dr. Bonnie Henry provided the Justice Policy Committee with this explanation of how these two types of orders worked during SARS:

> (f) requiring the person to whom the order is directed to submit to an examination by a physician and to deliver to the medical officer of health a report by the physician as to whether or not the person has a communicable disease or is or is not infected with an agent of a communicable disease;
>
> (g) requiring the person to whom the order is directed in respect of a communicable disease that is a virulent disease to place himself or herself forthwith under the care and treatment of a physician;
>
> (h) requiring the person to whom the order is directed to conduct himself or herself in such a manner as not to expose another person to infection.

[271] A virulent disease is a particularly hazardous communicable disease. Virulent diseases, as set out in regulations to the HPPA, include: (a) Cholera,(b) Diphtheria,(c) Ebola virus disease,(d) Gonorrhoea,(e) Hemorrhagic fever,(f) Lassa fever,(g) Leprosy,(h) Marburg virus disease,(i) Plague,(j) Syphilis, and (l) Tuberculosis. On March 25, 2003, SARS was specified as a virulent disease by an amendment to Ontario Regulation 95/03.

> Severe Acute Respiratory Syndrome (SARS) is specified as a virulent disease for the purposes of the Act. O. Reg. 95/03, s. 1.

[272] Subsection 35(1) provides:

> Order by Ontario Court of Justice
>
> > Upon application by a medical officer of health, a judge of the Ontario Court of Justice, in the circumstances specified in subsection (2), may make an order in the terms specified in subsection (3).
>
> Paragraph (a) of s. 35(2) provides:
>
> When court may make order
>
> > An order may be made under subsection (3) where a person has failed to comply with an order by a medical officer of health in respect of a communicable disease that is a virulent disease,
> >
> > (a) that the person isolate himself or herself and remain in isolation from other persons;
>
> Paragraph (a) of s. 35(3) provides:
>
> Contents of order
>
> > In an order under this section, the judge may order that the person who has failed to comply with the order of the medical officer of health;
> >
> > (a) be taken into custody and be admitted to and detained in a hospital or other appropriate facility named in the order;

> The Acting Chair: …. We heard during SARS that there were certain people who were restricted and were given isolation orders to stay in their homes.
>
> Dr. Henry: There were orders under section 22 of the *Health Protection and Promotion Act*, which basically required them to do what we said they needed to do to prevent the transmission of a disease.
>
> The Acting Chair: And what if they didn't?
>
> Dr. Henry: Then we had the potential to issue an order under section 35 in which we could detain them. We had the ability to go before a judge, but section 35 at the time said they must be detained in a hospital. That has since been changed so that we could, under section 35, require someone to stay in their home. Then we could work with our local police forces to enforce that.[273]

During SARS it was necessary to amend the *Health Protection and Promotion Act* when concerns arose about the possible community spread of SARS within a religious community. The story of this concern, and the notable cooperation of the religious group, BLD, will be told in the final report. The concern led to an amendment to the *Health Protection and Promotion Act* to provide that a s. 22 quarantine order (the original order by the medical officer of health described above) could be directed not only towards an individual but also to a named group of people.[274] The specific reason for the amendment was explained by Dr. Basrur at the Justice Policy Committee Hearings:

> One of the elements that arose during SARS was our inability to issue orders on anything but a person-by-person, one-at-a-time kind of basis. There was an instance wherein we had an entire group of people who needed to be put into quarantine on a weekend. It was physically and logistically impossible to issue orders person to person on a Saturday afternoon for 350 people who happened to live in three or four different health units all at once, each with their own MOH, their own solicitors and so on. So now there is an amendment to the Act. Again, that was processed even between phases one and two of the SARS outbreak. So things can happen fast when the will is there, but also when the need is apparent, such that orders can be issued against a class of persons. In a future pandemic or other wide-scale

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[273] Justice Policy Committee, Public Hearings, August 18, 2004, p. 159.

[274] Section 22 was amended to include s. 5.0.1 which provides:

Class order

> An Order under this section may be directed to a class of persons who reside or are present in the health unit served by the medical officer of health.

> emergency, that will be a very helpful provision so we can issue mass orders if necessary and if warranted under the circumstances.[275]

The power to quarantine any group, whether it is a tightly knit religious community or a student body must obviously be exercised with great sensitivity. Toronto Public Health officials, as will be noted in the final report, went out of their way to approach the concerned religious group with tact and understanding. Toronto Public Health sought, and received, a commendable level of cooperation from the leadership of the group. In times of crisis, however, it would be all too easy for officials with lesser sensitivity to act immediately, without consultation, and to think only later of the ensuing stigmatization, disruption, and confrontation.

It is therefore recommended that the proposed amendment be tempered to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.

While the *Health Protection and Promotion Act* now allows public health authorities to issue quarantine orders against both individuals and classes of persons, the lingering question remains of how to enforce these orders. This is particularly so in the case of class orders.[276]

The enforcement of class orders involves practical problems around the service requirements. Section 5.0.2 provides that if a class order is made, notice of the order shall be given to each member of the class, where practicable to do so.[277] However, s. 44(3) provides:

> (3) although a hearing is required in accordance with this Part, an order under this Act takes effect:

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[275] Justice Policy Committee, Public Hearings, August 18, 2004, p. 140.

[276] During a CBC interview with Michael Enright, Dr. Basrur stated: "In fact the statute was amended towards the end of phase one to give the medical officers of Ontario the powers to quarantine large numbers or classes of people because previously we only had the power to quarantine people one at a time. So if we had an apartment building for example or a community of interest that all needed to be in quarantine, we would have to go find them and serve them with a process server or a police officer one at a time, how ever many thousands of hours that would take. That's not an effective control measure. Now we can do it on a broader basis. The question of enforcement still applies but at least we can initiate it more quickly."

[277] If a class of persons is the subject of an order under subsection (5.0.1), notice of the order shall be delivered to each member of the class where it is practicable to do so in a reasonable amount of time. Subsection 5.0.3 provides:

> Same, general notice
>
> (5.0.3) If delivery of the notice to each member of a class of persons is likely to cause a delay that could, in the opinion of the medical officer of health, significantly increase the risk to the health of any person, the medical officer of health may deliver a general notice to the class through any communications media that seem appropriate to him or her, and he or she shall post the order at an address or at addresses that is or are most likely to bring the notice to the attention of the members of the class.

> (a) when it is served on the person to whom it is directed; or
>
> (b) in the case of an oral order or an order directed to a person described but not named in the order, when the person to whom it is directed first knows or ought to know the contents of the order.

Subsection 106(1) provides:

> Any notice, order or other document under this Act or the regulation is sufficiently given, served, or delivered if delivered personally or sent by ordinary mail addressed to the person to whom it is to be given, served or delivered at the person's last known address.

The difficulty with class orders is that they may be directed at individuals whose identity or description is unknown. For example, during SARS II, public health officials questioned whether they would issue a class order requiring all visitors and patients who had been inside a particular facility during a specific period to go into quarantine. They did not know the names of the visitors and patients so they would have been unable to "serve" them with notice within the meaning of the Act. The order contemplated would have had no legal effect because it would not have taken effect without service.

To clarify this problem, the Commission recommends a simple amendment to s. 106 to provide that in the case of a class order made under s. 5.0.2, service is effective when notice of the class order is posted and the order may be enforced as soon as it is brought to the actual attention of the person affected.

A final word is necessary about the unnecessary legal confusion surrounding the words "quarantine" and "isolation". Although the words are used indiscriminately and interchangeably there are technical legal distinctions between them. "Quarantine" is not a legally defined term in the *Health Protection and Promotion Act.* While, in popular parlance, thousands of people were quarantined during SARS they were actually, in a technical legal sense, isolated rather than quarantined. The problem is that the technical legal definitions are completely out of step with the actual language that everyone uses and understands.

Dr. Basrur pointed out to the Justice Policy Committee:

> Dr. Basrur: … We used the word "quarantine" because it was widely understood as being—
>
> The Acting Chair: But it technically was not.
>
> Dr. Basrur: No. It was an order to isolate yourself or to conduct yourself in such a way as not to expose another person. That would be the legal language under the Act.[278]

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[278] Justice Policy Committee, Public Hearings, August 18, 2004, p. 159.

Dr. Henry noted further:

> The term "quarantine" just doesn't appear in any of our legislative wording in Ontario. There's a Quarantine Act that is a federal act that only applies—the word only applies to people coming into the country … Right now the word "quarantine" and the action of quarantine actually only applies to the powers the federal government has. In legislation in Ontario we have the ability to isolate someone; we don't actually have the ability to quarantine someone.[279]

Because of the gap between what people understand by the word "quarantine" and its technical legal meaning, it is recommended that the word "quarantine" be introduced to the *Health Protection and Promotion Act* as a defined legal term to correspond to the universal popular understanding of that word as used during SARS.[280]

Recommendations

The Commission therefore recommends that:

- **Section 22(5.0.1) be amended to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.**

- **Section 106 of the *Health Protection and Promotion Act* be amended to provide that in the case of a class order made under s. 5.0.2, service is effective when notice of the class order is posted and the order may be enforced as soon as it is brought to the actual attention of the person affected.**

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[279] *Ibid.* p. 160.

[280] It is true that s.91. 11 of the *Constitution Act, 1867* assigns legislative authority over "Quarantine and the Establishment and Maintenance of Marine Hospitals" to Parliament. The scope of this power is unclear. It has not been subjected to detailed interpretation of the Supreme Court of Canada. However, the manner in which "quarantine" is conjoined to "marine hospitals", and the contiguity of the power with other items on the list suggests that its primary focus is control over Canada's shores and borders. This is arguably the focus of the federal *Quarantine Act*, R.S.C. 1985, c. Q-1. In addition, in his decision for the majority of the S.C.C. in *Schneider v. The Queen* (1982), 139 D.L.R. (3d) 417 (S.C.C.), Dickson J., as he was, quoted a passage from the report of the 1938 Royal Commission on Dominion-Provincial Relations (the Rowell-Sirois Commission) suggesting that the use of the term quarantine in s.91 referred to ship quarantine: "presumably ship quarantine." By contrast, provincial jurisdiction within the sphere of public health should permit a provincial legislature to legislate a quarantine power so long as the purpose of the latter is the protection of the public's health. Public health legislation in other provinces already provides for a quarantine power. See for instance British Columbia's *Heath Act*, R.S.B.C. 1996, c. 179, s.11(1); Alberta's *Public Health Act*, R.S.A. 2000, c. P-37, s. 29(1); *Manitoba's Public Health Act*, C.C.S.M. c. P210, s.12; and Newfoundland's *Communicable Diseases Act*, S.N.L. 1990, c. C-26, s.30.

- **The word "quarantine" be introduced to the *Health Protection and Promotion Act* as a defined legal term to correspond to the universal popular understanding of that word as used during SARS.**

Conclusion

Quarantine and isolation are essential measures in the defence against infectious outbreaks. SARS could not have been so quickly contained in Toronto without the tremendous public cooperation and individual sacrifice of those who were quarantined. While public health officials require the power to isolate those who are infected, and to quarantine those who may have been exposed to infection and may be infectious to others, this power comes with the responsibility to provide information, support, and job protection.

Recommendations

The Commission therefore recommends that:

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

- **The *Health Protection and Promotion Act* be amended to provide that it is a mandatory public health standard for each local medical officer of health to develop under the guidance of the Chief Medical Officer of Health a local plan in consultation with employers, educators, community groups, businesses, emergency responders, and health care facilities to ensure that plans are in place to ensure that those quarantined in the future have timely and adequate information, and the support necessary to encourage and enable them to comply with quarantine.**

- **The *Health Protection and Promotion Act* be amended to add a provision similar to s. 6(1) of the *SARS Assistance and Recovery Strategy Act*, to apply to infectious diseases as identified by the Chief Medical Officer of Health. The amendment should provide, in respect of such a disease, that a person is entitled to a leave of absence without pay where he or she is unable to work as a result of investigation or treatment related to the disease, or because he or she is subject to quarantine or isolation.[281] The amendment**

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[281] Section 6 (1) provides:

> During the period beginning March 26, 2003 and ending on a day specified by proclamation of the Lieutenant Governor under subsection 1(2), an employee is entitled to a leave of absence without pay for any day or part of a day during which he or she falls into one or more of the following categories:

should also protect those who are unable to work because they are needed to provide care or assistance to a spouse, child, grandparent, sibling or relative who is dependent on the employee for care and assistance.

- **Section 22(5.0.1) be amended to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.**

- **Section 106 of the *Health Protection and Promotion Act* be amended to provide that in the case of a class order made under s. 5.0.2, service is effective when notice of the class order is posted and the order may be enforced as soon as it is brought to the actual attention of the person affected.**

- **The word "quarantine" be introduced to the *Health Protection and Promotion Act* as a defined legal term to correspond to the universal popular understanding of that word as used during SARS.**

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1. The employee is unable to work because he or she is under individual medical investigation, supervision or treatment related to SARS.

2. The employee is unable to work because he or she is acting in accordance with a SARS related order under section 22 or 35 of the *Health Protection and Promotion Act*.

3. Subject to subsections (2) to (4), the employee is unable to work because he or she is in quarantine or isolation or is subject to a control measure in accordance with SARS related information or directions issued to the public, a part of the public or one or more individuals, by the Commissioner of Public Security, a public health official, a physician or a nurse or by Telehealth Ontario, the Government of Ontario, the Government of Canada, a municipal council or a board of health, whether through print, electronic, broadcast or other means.

4. The employee is unable to work because of a direction given by his or her employer in response to a concern of the employer that the employee may expose other individuals in the workplace to SARS.

5. The employee is unable to work because he or she is needed to provide care or assistance to an individual referred to in subsection (5) because of a SARS related matter that concerns that individual. 2003, c. 1, s. 6 (1).

9. Legal Access and Preparedness

SARS demonstrated weakness and confusion in the legal machinery for the enforcement of health protection orders under the *Health Protection and Promotion Act*, the legal engine that drives health protection. One lawyer told the Commission that their ability during SARS to give clear legal advice was at times hampered by weaknesses in the enforcement portions of the Act:

> During SARS, I would often say when asked if we could do something, 'you can try it, but if we are challenged we may be on shaky legal grounds and the courts will be in a very difficult position.'

The powers in the *Health Protection and Promotion Act* that authorize public health officials to make orders to protect the public are only as strong as the enforcement mechanisms that support them. Unless backed up by the power to enforce, an order is simply a request. Clarity in respect of enforcement powers is vital. Those who make orders and those who are obliged to comply with orders must know clearly in advance the consequences of noncompliance. Uncertainty is a prescription for trouble, doubly so in an emergency when there is no time to ponder and argue an uncertain power or an ambiguous enforcement procedure.

The *Health Protection and Promotion Act* requires amendment to ensure that the legal enforcement powers are strong and clear.

The following problems need to be addressed:

- The confusing tangle of enforcement powers.
- The procedural gaps within the enforcement machinery.
- The overlapping jurisdiction between the Ontario Court of Justice and the Superior Court.
- The lack of one-stop shopping for enforcement of orders.
- Uncertainty in the legal requirements for initiating and continuing enforcement procedures in court.
- The lack of systems to ensure legal preparedness in the application of enforcement machinery.

The Tangle of Enforcement Powers

The power to make orders lies primarily in three sections of the *Health Protection and Promotion Act:* s. 13,[282] which deals with environmental or occupational hazards; s. 22,[283] which deals with communicable diseases; and s. 86,[284] which allows the Chief Medical Officer of Health to act in the face of a health risk.

These three sections each have their own court enforcement route whenever a public health official seeks to compel the subject of the order to comply. In a completely different parallel process, the Health Services Appeal and Review Board under the *Ministry of Health Appeal and Review Boards Act, 1998*,[285] becomes involved whenever the subject of an order requests a hearing.[286] From that board there is an appeal to the Divisional Court, and if leave to appeal

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[282] Subsection 13(1) provides:

> A medical officer of health or a public health inspector, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard.

[283] Subsection 22(1) provides:

> A medical officer of health, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease.

[284] Subsection 86(1) provides:

> If the Chief Medical Officer of Health is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.

[285] S.O. 1998, c. 18, Sched. H.

[286] Sections 44 through 46 deal with the review of orders by the Health Services Appeal and Review Board and the appeal process that follows. Those sections provide:

> 44(1) An order by a medical officer of health or a public health inspector under this Act shall inform the person to whom it is directed that the person is entitled to a hearing by the Board if the person mails or delivers to the medical officer of health or public health inspector, as the case requires, and to the Board, within fifteen days after a copy of the order is served on the person, notice in writing requiring a hearing and the person may also require such a hearing.
>
> Oral order
>
> (2) An oral order or an order directed to a person described but not named in the order need not contain the information specified in subsection (1) but a person to whom the order is directed may require a hearing by the Board by giving the notices specified in subsection (1) within fifteen days after the day the person first knows or ought to know the contents of the order. R.S.O. 1990, c. H.7, s. 44 (2).
>
> Effect of order
>
> (3) Although a hearing is required in accordance with this Part, an order under this Act takes effect,

(a) when it is served on the person to whom it is directed; or

(b) in the case of an oral order or an order directed to a person described but not named in the order, when the person to whom it is directed first knows or ought to know the contents of the order,

but the Board, upon application with notice, may grant a stay until the proceedings before the Board are disposed of.

Powers of Board

(4) Where the person to whom an order is directed requires a hearing by the Board in accordance with subsection (1) or (2), the Board shall appoint a time and place for and hold the hearing and the Board may by order confirm, alter or rescind the order and for such purposes the Board may substitute its findings for that of the medical officer of health or public health inspector who made the order.

Time for hearing

(5) The Board shall hold a hearing under this section within fifteen days after receipt by the Board of the notice in writing requiring the hearing and the Board may, from time to time, at the request or with the consent of the person requiring the hearing, extend the time for holding the hearing for such period or periods of time as the Board considers just.

Extension of time for hearing

(6) The Board may extend the time for the giving of notice requiring a hearing under this section by the person to whom the order of the medical officer of health or public health inspector is directed either before or after the expiration of such time where it is satisfied that there are apparent grounds for granting relief to the person following upon a hearing and that there are reasonable grounds for applying for the extension, and the Board may give such directions as it considers proper consequent upon the extension.

Parties and evidence

45. (1) The medical officer of health or public health inspector who made the order, the person who has required the hearing and such other persons as the Board may specify are parties to the proceedings before the Board.

Examination of documentary evidence

(2) Any party to the proceedings before the Board shall be afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced or any report the contents of which will be given in evidence at the hearing.

Members holding hearing not to have taken part in investigation, etc.

(3) Members of the Board holding a hearing shall not have taken part before the hearing in any investigation or consideration of the subject-matter of the hearing and shall not communicate directly or indirectly in relation to the subject-matter of the hearing with any person or with any party or representative of the party except upon notice to and opportunity for all parties to participate, but the Board may seek legal advice from an advisor independent from the parties and in such case the nature of the advice shall be made known to the parties in order that they may make submissions as to the law.

Recording of evidence

(4) The oral evidence taken before the Board at a hearing shall be recorded and, if so required, copies or a transcript thereof shall be furnished upon the same terms as in the Superior Court of Justice.

is granted, a further appeal to the Ontario Court of Appeal. This cumbersome appeal system stands in contrast to the system by which labour injunctions are appealed directly to the Court of Appeal to eliminate the time-consuming process of an intervening appeal to the Divisional Court and the uncertainty whether leave will be granted to appeal further to the Court of Appeal. The Commission recommends that the *Health Protection and Promotion Act* be amended to eliminate this complex appeal process, rife with delay, and provide an appeal as of right directly to the Court of Appeal with no prior requirement to secure leave to appeal.

The Commission has had no opportunity in the course of preparing this interim report to study the impact on enforcement of the injection into the judicial enforcement process of the Health Services Appeal and Review Board process. It is, however, logical to ask whether it is appropriate to have this confusing and time-consuming parallel mixture of separate judicial and administrative procedures when infection is spreading and time is of the essence. Considering the need during an infectious outbreak for speed and one-stop shopping, it is logical to ask whether it would be better to remove the board from the process and to

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Release of documentary evidence

(6) Documents and things put in evidence at a hearing shall, upon the request of the person who produced them, be released to the person by the Board within a reasonable time after the matter in issue has been finally determined.

Appeal to court

46. (1) Any party to the proceedings before the Board under this Act may appeal from its decision or order to the Divisional Court in accordance with the rules of court.

Stay of order

(2) Where an appeal is taken under subsection (1) in respect of an order that was stayed by the Board, a judge of the Superior Court of Justice upon application may grant a further stay until the appeal is disposed of

Record to be filed in court

(3) Where any party appeals from a decision or order of the Board, the Board shall forthwith file with the Divisional Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Board's record, shall constitute the record in the appeal.

Minister entitled to be heard

(4) The Minister is entitled to be heard, by counsel or otherwise, upon the argument of an appeal under this section.

Powers of court on appeal

(5) An appeal under this section may be made on questions of law or fact or both and the court may confirm, alter or rescind the decision of the Board and may exercise all powers of the Board to confirm, alter or rescind the order as the court considers proper, or the court may refer the matter back to the Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper.

substitute a hearing before a Superior Court judge as part of the process of consolidating all powers and procedures in one forum.

The discussion below will focus on the enforcement of orders in the face of noncompliance. The following comments and recommendations apply only to procedures in respect of orders made under Part IV (Communicable diseases) and Part VII (Administration). It is in these two parts of the *Health Protection and Promotion Act* that the enforcement powers of the local medical officers of health and the Chief Medical Officer of Health in respect of communicable diseases are found. The Commission makes no recommendations in respect of the enforcement procedures set out in Part III of the Act.

An order made under s. 22, in relation to a virulent disease, may be enforced in the Ontario Court of Justice, through an application under s. 35 of the *Health Protection and Promotion Act*. Section 35[287] authorizes the Court to order that a person be taken into custody and detained, examined by a physician to determine if infected with the agent of a virulent disease, and, where infected, treated. An Ontario Court of Justice order under s. 35, enforcing a public health order made under s. 22, may be appealed to a judge of the Superior Court and may be further appealed to the Court of Appeal but only if a judge of that court, in a separate hearing, grants special leave to appeal on a question of law alone. Although it is sensible that the appeal goes directly to the Court of Appeal without a time consuming intermediate appeal to the Divisional Court, the requirement of special leave creates delay. The restriction of the appeal to a question of law alone restricts the access to justice of someone affected by an order that significantly infringes his individual rights. The Commission recommends that this complex appeal process, which produces delay and restricts access to justice, be simplified. This process could be simplified by eliminating the intermediate appeal to the Superior Court or the restricted leave to appeal to the Court of Appeal or both.

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[287] Subsection 35(1) provides:

> Upon application by a medical officer of health, a judge of the Ontario Court of Justice, in the circumstances specified in subsection (2), may make an order in the terms specified in subsection (3)
>
> (2) An order may be made under subsection (3) where a person has failed to comply with an order by a medical officer of health in respect of a communicable disease that is a virulent disease,
>
> > (a) that the person isolate himself or herself and remain in isolation from other persons;
> >
> > (b) that the person submit to an examination by a physician;
> >
> > (c) that the person place himself or herself under the care and treatment of a physician; or
> >
> > (d) that the person conduct himself or herself in such a manner as not to expose another person to infection.
>
> (3) In an order under this section, the judge may order that the person who has failed to comply with the order of the medical officer of health,
>
> > (a) be taken into custody and be admitted to and detained in a hospital or other appropriate facility named in the order;
> >
> > (b) be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and
> >
> > (c) if found on examination to be infected with an agent of a virulent disease, be treated for the disease.

Orders made under s. 22 that do not relate to virulent diseases or that require action other than detention, examination or treatment, must be enforced through s. 102 of the Act. If the order relates to virulent disease and involves detention, examination or treatment, the order is enforced in the Ontario Court of Justice, through the quasi-criminal machinery of the *Provincial Offences Act*. If the order is of any other kind, it is enforced in the Superior Court pursuant to s. 102, through the civil machinery of the *Rules of Civil Procedure*.[288] In an earlier day and age this arcane mixture of proceedings may have appeared logical. In times like these when disease can strike overnight, clarity, speed, and unified procedures are required. The Commission recommends that this multiplicity of procedures be replaced by a single, simple, codified procedure in the Superior Court.

Section 102 contains two parts: s. 102(1), which allows a court to restrain the contravention of an order, and s. 102(2), which allows a court to prohibit continuation or repetition of a contravention.[289]

If this were not complex enough it must be remembered, as noted above, that s. 86 of the *Health Protection and Promotion Act* provides a completely separate and parallel duplicate system of enforcement in respect of orders made by the Chief Medical Officer of Health in respect of a health risk. Where an order is made under s. 86, by the Chief Medical Officer of Health, the enforcement of that order is governed by s. 86.1,[290] which authorizes an application to the Superior Court. Under s. (2), the court may order a board of health to take or refrain from taking action where there is a health risk. It does not authorize the court to make an order against anyone other than boards of health.

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[288] R.R.O. 1990, Reg. 194. The *Rules of Civil Procedure* are enacted as a regulation to the *Courts of Justice Act*, R.S.O. 1990 c. C. 43.

[289] Subsection 102(1) provides:

> Despite any other remedy or any penalty, the contravention by any person of an order made under this Act may be restrained by order of a judge of the Superior Court of Justice upon application without notice by the person who made the order or by the Chief Medical Officer of Health or the Minister. Proceedings to prohibit continuation or repetition of contravention.
>
> Proceedings to prohibit continuation or repetition of contravention
>
> 102(2) Where any provision of this Act or the regulations is contravened, despite any other remedy or any penalty imposed, the Minister may apply to a judge of the Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention by the person committing the contravention, and the judge may make the order and it may be enforced in the same manner as any other order or judgment of the Superior Court of Justice.

[290] Section 86.1 provides:

> If the Chief Medical Officer of Health is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may apply to a judge of the Superior Court of Justice for an order under subsection (2).

Therefore, if the Chief Medical Officer of Health makes an order under s. 86 that is directed at an individual, institution or organization other than a board of health, she too must resort to the enforcement powers in s. 102.

The wording of s. 102(1) is unclear and confusing. Subsection (1) authorizes a restraining order;[291] an order to stop someone from doing something. It does not authorize a mandatory order; an order to require someone to do something. Subsection 102(2), which was obviously intended to add some additional power, is unclear in its purpose, intention, and scope. It can only be triggered by the Chief Medical Officer of Health or the Minister. It contains the same problem as s. (1) in the sense that it does not provide for a mandatory order.

This lack of mandatory power in s. 102 has led public health lawyers to have to frame their argument in a reverse fashion. For example, instead of asking the court to order a person to comply with an order of a medical officer of health, the court order must be to refrain from noncompliance with the order of a medical officer of health: a double negative along the lines of "Don't not do what you have been ordered to do," instead of "do what you have been ordered to do."

The Superior Court procedure set out in s. 102 is confusing and weak. This is no way to enforce a statute. The Commission recommends that the *Health Protection and Promotion Act* be amended to provide the Superior Court, when ordering compliance with a public health obligation, with a full range of remedial power including the power to make mandatory orders.

What the *Health Protection and Promotion Act* lacks, and what it needs, is a single, clear, one-stop shopping system for the enforcement of all public health orders in respect of communicable diseases. Jurisdiction to enforce public health orders is divided artificially and confusingly between the Superior Court and the Ontario Court of Justice. The Ontario Court of Justice, if the subject of an order does not comply in response to an order in relation to a virulent disease, may order compliance. The Superior Court may make a similar order. As noted in greater detail below, each court has different procedures, none of them tailor-made for the purpose of public health protection. None of the legal procedures are designed for the delicate task of balancing individual rights against the right of the public to be protected against infectious disease. None of the legal procedures is designed for the speed required in an emergency.

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(2) If an application is made under subsection (1), the judge,

(a) may order the board of health of a health unit in which the situation causing the risk exists to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk caused by the situation; and

(b) may order the board of health of a health unit in which the health of any persons is at risk as a result of a situation existing outside the health unit to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk to the health of the persons in the health unit.

[291] An application under s. 102(1) may be made without notice, although a judge can always require notice if the circumstances appear to require it.

The problem of overlapping jurisdiction is compounded by a number of constitutional rules which severely limit the power of the Ontario Court of Justice to issue certain kinds of orders and to grant certain kinds of remedies.

The Provincial Court lacks constitutional authority to make orders of the kind contemplated in s. 102 of the *Health Protection and Promotion Act*, which provides for Superior Court orders to restrain the contravention of public health orders and to prohibit the continuation of the contravention of such orders. In some specified circumstances the order may be made without notice and in other cases a judge may, under the inherent power of the court and the *Rules of Civil Procedure*, proceed without notice on an interim basis subject to a later hearing.

Orders of the kind required for a full range of enforcement procedures, orders in the nature of mandatory orders or orders for injunctions, are constitutionally reserved to the exclusive authority of the Superior Court. Even if Ontario passed a statute to give the Ontario Court of Justice such power, the statute would be constitutionally dubious in the sense of invalid and ineffective[292] on the grounds that the province cannot give such power to a provincially appointed judge. A similar problem arises from the limited jurisdiction of the Ontario Court of Justice to grant remedies under the *Canadian Charter of Rights and Freedoms* because rigid constitutional doctrines reserve that power primarily to the Superior Court.[293] It is only in Superior Court that the availability of a full range of Charter remedies is constitutionally unassailable.

These constitutional limitations on the jurisdiction of the Ontario Court of Justice complicates matters unnecessarily for those who seek to enforce public health orders, or those who seek remedies for the alleged infringement of their legal rights. It makes no sense to divide public health enforcement and public health remedies so confusingly between two different courts.

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[292] Section 96 of the *Courts of Justice Act* confers on non-superior courts the power to apply the rules of equity but not the power to grant equitable relief, including injunctive relief: see also *Moore v. Canadian Newspapers Co.* (1989), 60 D.L.R. (4th) 113 (Div. Ct.). Altering this jurisdiction, even indirectly, would be difficult. Historically, Canadian courts have been vigilant in limiting efforts by provincial legislatures to enhance the jurisdictions of non-superior courts and statutory tribunals. The Supreme Court of Canada has repeatedly allowed challenges to purported extensions of the powers of non-superior courts and tribunals: see for example *Re Residential Tenancies Act* [1981] 1 S.C.R. 714.

[293] Section 24(1) of the *Canadian Charter of Rights and Freedoms* limits remedial jurisdiction to courts of "competent jurisdiction." Provincial superior courts are always courts of competent jurisdiction; they constitute the "default court of competent jurisdiction" for the purpose of Charter applications: *Doucet-Boudreau v. Nova Scotia (Minister of Education)* [2003] 3 S.C.R. 3 at para 49. By contrast, a non-superior court is a court of competent jurisdiction to grant a Charter remedy only if it has the power independently of the Charter to grant that remedy: *R. v. 974649 Ontario Ltd.* [2001] 3 S.C.R. 575.

Legal clarity and simplicity is vital in the enforcement of public health orders and the availability of legal remedies to those affected by orders. Multiplicity of courts and procedures produces nothing but delay and confusion. One court should have unified jurisdiction over all public health enforcement procedures and remedies. Without one-stop shopping in one court and one single code of procedure, the application of public health law will be hopelessly cumbersome. Unfortunately the rigidity of constitutional doctrines around court jurisdiction give no choice as to which court should have the full jurisdiction to enforce public health orders and grant remedies to individuals. The one court with that plenary jurisdiction is the Superior Court. The Commission recommends that the *Health Protection and Promotion Act* be amended to provide that all public health enforcement and remedial procedures be taken in the Superior Court pursuant to a unified code of procedure to be enacted with the Act.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to eliminate the complex appeal process, rife with delay, in respect of an appeal by the subject of an order from a decision of the Health Services Appeal and Review Board, and provide an appeal as of right directly to the Court of Appeal with no prior requirement to secure leave to appeal.**

- **The Ministry of Health and Long-Term Care consider whether the Health Services Appeal and Review Board is a necessary step in the complex hearing and review process in the *Health Protection and Promotion Act* or whether some other system should be enacted.**

- **The *Health Protection and Promotion Act* be amended to simplify the complex and restrictive appeal process in respect of appeals from provincial court to the Superior Court and then to the Court of Appeal but only if a judge of the Court of Appeal grants leave to appeal on special grounds on a question of law alone. This process could be simplified by eliminating the intermediate appeal to the Superior court the restricted leave to appeal to the Court of Appeal or both.**

- **The multiplicity of procedures in respect of the enforcement of Orders made under Part IV (communicable diseases) and Part VII (administration) of the *Health Protection and Promotion Act*, be replaced by a single, simple, codified procedure in the Superior Court.**

- **The *Health Protection and Promotion Act* be amended to provide the Superior Court, when ordering compliance with a public health**

obligation, with a full range of remedial power, including the power to make mandatory orders.

Procedural Uncertainty

To complicate matters further the *Health Protection and Promotion Act* does not even contain all the rules for the enforcement of health protection orders. Some of these rules are found in the *Provincial Offences Act*, a quasi-criminal statute that codifies many of the procedures for the enforcement of Ontario laws like the *Highway Traffic Act*[294] that provide for prosecutions and punishments. For Superior Court procedures, the compendious and complex *Rules of Civil Procedure* must be followed. It is unacceptable that those enforcing public health protection have to wrestle with a multiplicity not only of courts, but of outside procedural regimes such as the *Provincial Offences Act* and the *Rules of Civil Procedure.*

For example, s. 86.1(1) of the *Health Protection and Promotion Act,* which allows the Chief Medical Officer of Health to resort to the Superior Court for an order directing a board of health to act in a situation where there is a health risk, says nothing about notice requirements or the procedural aspects of the application, for which one would have to consult the compendious and complex *Rules of Civil Procedure.*

To those who simply want to get on with the urgent business of enforcing public health orders or securing remedies in respect of those orders, the present law presents a confusing maze of overlapping and uncertain judicial powers and procedures best described as a legal nightmare.

One public health legal expert described a few of the problems:

> [T]here is no procedure provided under the HPPA for obtaining a s. 35 order, there is nothing really prescribed under the HPPA for how you go about getting a s. 35 order. Actually in the case of SARS it was unclear whether s. 35 was really what was needed, given that for the most part, the types of orders that we would have wanted to enforce were home quarantine orders and whether s. 35 was really the right tool for enforcing a home quarantine order, raises questions given that you are going to be taking someone out of their house and detaining them in a hospital under s. 35 and whether that is really what you want to do in those circumstances.
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> … I guess one of the other revelations in doing research into it was that if there was any procedure provided for obtaining a s. 35 order, it appears to be under the *Provincial Offences Act*, s. 161 of the *Provincial Offences Act.*
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> I think in a nutshell … that is not where most of us really expect it to be. Most people think of it really as a civil kind of an injunction or application. They do not think of it as a criminal type of procedure and I think there is

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[294] R.S.O. 1990, c. H-8.

> some confusion between the proceedings under s. 35 and those that are permitted under s. 102 that allows you to go *ex parte* [in the absence of the person against whom an order is sought] to the Superior Court to obtain an order. We were very focused on s. 35 because it deals specifically with communicable diseases. It seems to have everything you want to do under s. 35 but when you actually look more closely into it, it is actually more of a straightjacket to what you want to do than would be the case under s. 102. It is very specific on what you are allowed to get.
>
> If you look at s. 35(3) it basically prescribes the order that you can get and it says that the person may be taken into custody, admitted and detained in a hospital, now it has been amended to say other appropriate facility named in the order, to be examined by a physician and, if found on examination to be infected, to be treated. So that is what it allows you to get. My question was if you just wanted people to stay home, and that is what you wanted to enforce, and you were not getting police assistance otherwise, and the police may not give you any assistance unless you get a court order, is this what you really want?
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> I think that at first glance, it seems to be a procedural void. When you first look at the HPPA, you think there is no procedure here for obtaining this. When you look at s. 161 of the POA, your second impression is, I am going to the Ontario Court of Justice but what does the Ontario Court of Justice do? It normally does provincial offences or it does custody and access kind of disputes. So you are thinking, do I make it look like a custody and access application or do I make it look like some sort of a provincial offences application, otherwise they may not let me file this anywhere.

This highlights many areas of confusion in the current system of court enforcement. It is inappropriate to enforce a public health order in the Ontario Court of Justice through the quasi-criminal provisions of the *Provincial Offences Act*, which were never designed for that purpose. It is inappropriate in the Ontario Court of Justice (Provincial Court) or the Superior Court to use a system of procedure that was never designed for the special problems of public health enforcement.

The lack of certainty as to whether the law requires the presence at the hearing of the person sought to be quarantined is particularly troublesome. Applications under s. 35 of the *Health Protection and Promotion Act*, in which the court is asked to enforce a quarantine order made by the medical officer of health, are brought in the Ontario Court of Justice. These orders are governed by the quasi-criminal procedures of the *Provincial Offences Act*, which requires in s. 161(b) that parties be given an opportunity to respond to any application.[295] This

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[295] Subsection 161(b) provides:

> Where, by any other Act, a proceeding is authorized to be taken before the Ontario Court of Justice or a justice for an order, including an order for the payment of money, and no other procedure is provided, this Act applies with necessary modifications to the proceeding in the same manner as to a proceeding commenced under Part III, and for the purpose,

requirement can be impracticable in a public health emergency when a noncompliant infected person cannot be found immediately. The requirement of notice and an immediate opportunity to be heard before even a temporary order can be made, may be impracticable if there is no machinery in place to ensure the infected person can safely be brought to court without endangering the health of everyone in the courthouse. It might be sensible to make an initial temporary order in the Ontario Court of Justice without notice to the person involved, subject to review at a telephone or video hearing within a day or two in which he or she could participate electronically. However sensible it might be to do so, it is questionable whether there is jurisdiction to do so. One expert in the field noted:

> If in fact the Ontario Court judge is saying, 'well what I am going to do is on an interim basis, I am going to allow you to get police assistance to keep them at home and then it is returnable in a few days.' The question is: is that really a substantive order under s. 35? Is he really making a determination that is not what that judge is permitted to make under s. 35. Is there a substantive element to that?

There are obvious problems with rules that require a public court attendance by someone who should be quarantined because he poses a risk of transmitting a virulent disease. It makes no sense to invite the virulent infection into the courthouse where others may be endangered and the entire court process may be jeopardized. The risk, which the law seeks to reduce, may in fact be increased by the procedure required to reduce it.

One expert familiar with the process described the problem to the Commission as follows:

> … Well, can I do this *ex parte* [in the absence of the person against whom an order is sought?] Can I not do this *ex parte*? … And every time I get a 35 I cringe because of this whole procedural quagmire, because the judges rightly so have never seen such applications. It was very rare before SARS … And they are concerned about the health of their staff, the court officials and legitimately so. They do not want them there at first instance. Do I give the person notice, do I not? Do I go there and try to get an interim order and then have them appear by teleconference or through an agent? And the real risk, we were very cognizant of this, what if we give them notice and they take public transportation to the place. Do we have to stand outside their houses and give them a mask. What is our authority to put a mask on them? This became very real in SARS. But even in a case we had after SARS with a TB patient, we did not know what to do with this person. You give them notice at first instance but they go on public transportation. Do we have to send them a cab and which cab company would take them. How do we

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(a) in place of an information, the applicant shall complete a statement in the prescribed form under oath attesting, on reasonable and probable grounds, to the existence of facts that would justify the order sought; and

(b) in place of a plea, the defendant shall be asked whether or not the defendant wishes to dispute the making of the order.

> force them to wear masks because contempt [of court power] would be too late. And what I notice about the people who have to get s. 35 orders against them, they do not believe that they have the disease. The common thread through every single s. 35 that I have done, is that they do not believe they have the disease. So they will get on public transportation, they will walk, they will do whatever, because they think this thing has been blown out of proportion. I think we need circumscribed set of circumstances. You can go *ex parte* initially, have a first cut at it, you can go *ex parte*, you can go with a three day order; have them at least assessed quickly, do you have TB, or do you not? That could be done I think pretty quickly.

Another suggested that many of the procedural difficulties could be resolved by sending all the enforcement applications to the Superior Court, which has more familiarity with *ex parte* procedures and interlocutory relief, and wider constitutional power than the Ontario Court of Justice:

> My preference with respect to these issues perhaps shows my roots as a civil litigator. It is to do away with the Ontario Court procedures and just have these applications in Superior Court. There is a familiarity of civil court judges for interlocutory procedures ultimately resulting in a restraining order or an order requiring one to remain in a particular place. It is not going to be, I believe, as much of an educational process … I do not see there being any real purpose in having these two separate processes that you can go to the Ontario Court or you can go to the Superior Court. Again I am showing my roots but my preference would be to go to the Superior Court to seek that type of relief. I do not anticipate there would be any kind of delay involved in going to Superior Court … That court would have greater familiarity with dealing with *ex parte* proceedings than would the Ontario Court because it really is not an offence based request by the medical officer of health, it is a request for interlocutory relief to detain someone. Now if you were to go that route to require that such applications are always made to the Superior Court, then you could still flesh out what types of orders could be made, including order more expansive than what is in s. 35(3) right now, and clarify in there that the judges can request and require the assistance of the police and all of that sort of thing. I do not know necessarily if the judges would require that sort of thing but I think that they would be fairly familiar with those types of terms, in restraining orders and the like. You could have a fairly clear process set out by which these applications would be made. But I think that you could make it more clear by going to the Superior Court.

As noted above, the powers of judicial enforcement are scattered throughout the Act between two separate courts without any procedural guidance or explicit machinery for crucial procedures such as dispensing with hearings, determining whether a hearing should be open to the public, or amending orders as conditions change. It is not the time, in the middle of an infectious outbreak or even before it starts, for medical officers of health and their lawyers to navigate the substantive and procedural mysteries of this confusing and inadequate legal system.

Another area that requires amendment for procedural clarity is the power of medical officers of health to obtain police assistance in the enforcement of s. 35 orders. Subsection 35(6) provides:

> Section 35(6) provides:
>
> An order under this section may be directed to a police force that has jurisdiction in the area where the person who is the subject of the order may be located, and the police force shall do all things reasonably able to be done to locate, apprehend and deliver the person in accordance with the order.

Uncertainty ensues when the person crosses boundaries into another health unit, with a different police service. One medical officer of health described the problem with this section to the Commission:

> There have been cases where a judge has issue a s. 35 order and circumstances required the services of a police department in a jurisdiction outside that of the health unit who applied for the s. 35 order, and the police refused to carry out the order claiming that because it was from outside it did not apply to them.

The Commission recommends that the *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found, and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.

It is not enough to provide legal authority to make orders. If the orders cannot be enforced through a clear set of reasonable and efficient procedures, there is no point in making the order in the first place. The procedures to exercise those powers must be in place and must be clear and fair. They must be learned thoroughly by all those involved in their application. As one expert from the Centers for Disease Control and Prevention observed:

> … obviously you have to have the authority, you have to have the legal authority to do so. But you need more than that. You need procedures. You can have the authority but you need procedures. How is this actually going to work and those procedures have to be fair, they have to conform with the constitution of the United States, they have to allow due process in that sense, 14th amendment. They have to be defendable. These may have to be defended in court sometime and so they must be defendable legally. To be legally prepared, you have to have legal expertise in this state. People who understand these laws, how to use them, what their limits are. Coordination along jurisdictions is absolutely crucial … We learned this and we could learn it again with other public health challenges. And you need communications, three times, communications and education amongst all law officials, law enforcement and judiciary.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to consolidate and codify all provisions in respect of court enforcement and access to judicial remedies in respect of communicable diseases into one seamless system or powers and procedures.**

- **The *Health Protection and Promotion Act* be amended to include special procedures such as *ex parte* procedures for interim and temporary orders, video and audio hearings, and other measures to prevent the court process from becoming a vector of infection.**

- **The *Rules of Civil Procedure* be amended to include a clear, self-contained and complete code of procedure for public health enforcement and remedies in respect of communicable diseases.**

- **There be a consequential amendment to the *Courts of Justice Act* to provide that proceedings in respect of the *Health Protection and Promotion Act* enforcement and remedies in respect of communicable diseases shall be heard at the earliest opportunity.**

- **The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found, and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.**

- **The judiciary be asked to establish court access protocols in consultation with the public health legal community.**

- **The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found, and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.**

- **The Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General, together with public health officials, establish protocols and plans for the enforcement of orders under the *Health Protection and Promotion Act* and the involvement of police officers in that process.**

Legal Preparedness

Legal counsel for public health units faced a daunting task during SARS. When seeking judicial authority to enforce an order, they had to navigate a confusing maze of overlapping and uncertain judicial powers and procedures when speedy enforcement was vital to the containment of SARS. As one lawyer involved in the response to SARS told the Commission:

> It is quite a challenge to be in a middle of an emergency with the kind of huge range of legal issues coming up and you have to figure out what the legal requirements are and how to get what needs to be done, done in the face of those issues and still keeping everyone within the law.

SARS demonstrated that it is vital in the middle of an infectious outbreak to be able to get a judicial order quickly and to enforce it quickly.

Legal preparedness is seen increasingly as an essential element of public health preparedness, like epidemiological preparedness or diagnostic preparedness. As noted in a paper published by the Centers for Disease Control and Prevention:

> Historically, public health legal counsels have served as "technicians" in public health practice, asked by the public health agencies they serve to interpret arcane statutory language and render opinions. Legal preparedness, however, is increasingly being viewed as a critical component of state and local government public health preparedness activities. As demonstrated repeatedly, in the SARS outbreak (quarantine/isolation); in the introduction of monkey-pox in the Western Hemisphere (restrictions upon the exotic animal pet trade); and during West Nile virus season (mosquito abatement/spraying programs), legal issues are nearly always intertwined with public health responses.[296]

A group of American public health experts added:

> Legal preparedness has gained recognition as a critical component of comprehensive public health preparedness for public health emergencies triggered by infectious disease outbreaks, natural disasters, chemical and radiologic disasters, terrorism and other causes. Public health practitioners and their colleagues in other disciplines can prepare for and respond to such an event effectively only if law is used along with other tools. The same is true for more conventional health threats.[297]

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[296] James J. Misrahi, Joseph A. Foster, Frederic E. Shaw and Martin S. Cetron, "HHS/CDC Legal Response to SARS Outbreak," in Emerging Infectious Diseases, Vol. 10, No. 2, February 1994, pp. 354-355.

[297] Anthony D. Moulton, Richard N. Gottfried, Richard A. Goodman, Anne M. Murphy and Raymond D. Rawson, "What is Public Health Legal Preparedness," Journal of Law, Medicine and Ethics, 31 (2003), p. 10

Public health lawyers in Ontario distinguished themselves during SARS by the initiatives they took to overcome the marked lack of systemic legal preparedness. Their hard-earned expertise inspired U.S. officials to develop new approaches to legal preparedness. An expert at the Centers for Disease Control and Prevention, for example, credited a presentation by Jane Speakman, Toronto Public Health's legal counsel, and Dr. Barbara Yaffe of Toronto Public Health, as a central element in the Centers for Disease Control and Prevention's development of a legal preparedness guide:

> This is something that we developed and posted, based upon some collaboration after hearing Jane Speakman and [Dr.] Barbara Yaffe present at the Phoenix Health Officers Conference in September. Then on the plane ride back, we started putting that together for the lawyers and the health officers in this country to get ready for SARS. So a lot of this is part of the presentation they had given together with some of things we had been thinking about for folks in this country, getting ready for SARS when it comes again. Know your legislation. Plan due process. Draft your documents in advance. Contact your other jurisdictions. Alert your judiciary. Plan for the practical problems in communication as filed. This is a work in progress … I heard very early in conference calls with Toronto that when they went to the judges, the judges were a little surprised. What is this law that you can issue an order without it first coming before the judiciary. That's the way many laws are in this country. That's the way our federal authority is. You can do it *ex parte*. And, and my understanding is that the judiciary was concerned with two parts: one, we've got to be sure that the law enforcement officials that are carrying out this are properly protected. What are the personal protective equipment and those rules of separation. And there needs to be legal representation for people that are put under order and that's where we're starting to draw this in. You've got to plan the due process.

Although the role of law in public health is not new, SARS underlined the importance of having not only the right laws and regulations in place, but also the ability to enforce them quickly and fairly. The current emphasis on legal preparedness reflects the perspective of James A. Tobey, the American public health legal scholar, who stated more than 50 years ago:

> … practical laws, reasonably and equitably enforced, are essential as a foundation for the public health activities of government. Education and moral suasion, desirable as they may be in the practice of public health, will not bring results unless the people realize that behind them is the long arm of the Law.[298]

Public health legal preparedness takes many forms and reaches into all aspects of emergency response. A group of American public health experts noted;

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[298] James A. Tobey, "Public Health Law," (The Commonwealth Fund, New York: 1947), p. 3.

> At first glance, public health legal preparedness may appear to be only a matter of having the right laws on the books. On closer examination, however, it is as complex as the field of public health practice itself. Public health legal preparedness has at least four core elements: laws (statutes, ordinances, regulations, and implementing measures); the competencies of those who make, implement, and interpret the laws; information critical to those multidisciplinary practitioners; and coordination across sectors and jurisdictions.[299]
>
> SARS demonstrated the importance of clearly drafted and well understood legal procedures in the containment of infectious outbreaks.[300] The need for clarity and speed was stressed by a public health lawyer who responded to SARS; a procedure for obtaining a section 35 order should be fully outlined in section 35 of the *Health Protection and Promotion Act*. This procedure should set out the most expeditious manner of providing individuals with rights to due process while at the same time expediting the process to reduce the potential transmission of disease.

As part of legal preparedness, public health officers need to be familiar with the legal procedures required to isolate infectious people and to quarantine exposed people. Courts need judicial education programmes to familiarize judges with the law, procedure, and practical challenges of public health enforcement powers and remedies. Protocols for court access, including electronic hearings and access to legal aid, need to be developed in consultation with private lawyers and public health officials. Echoing the experience of Ontario, the Centers for Disease Control and Prevention advises:

> Public health officers need to be prepared for the practical problems that may arise in affording adequate due process protections to persons subject to isolation and/or quarantine orders. Such problems may include how to arrange for the appearance and representation of persons in quarantine (e.g., video conference or other remote means); how to serve an isolation/quarantine order (likely through law enforcement) and other procedures to advise persons of their legal rights; and isolation arrangements for transient or homeless populations.[301]

In addition, echoing another lesson also learned in Ontario during SARS, the Centers for Disease Control and Prevention advises:

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[299] Anthony D. Moulton, Richard N. Gottfried, Richard A. Goodman, Anne M. Murphy and Raymond D. Rawson, "What is Public Health Legal Preparedness," Journal of Law, Medicine and Ethics, 31 (2003), p. 10.

[300] See: The Centers for Disease Control and Prevention has published a useful guide entitled: "Fact Sheet: Practical Steps for SARS Legal Preparedness."

[301] Centers for Disease Control and Prevention, "Fact Sheet: Practical Steps for SARS Legal Preparedness," January 8, 2004.

> … public health officers should consider drafting key documents in advance of an emergency. These template documents can be critical time savers in an emergency. Documents that jurisdictions should consider preparing in advance include: draft quarantine and/or isolation orders; supporting declarations and/or affidavits by public health and/or medical personnel; and an explanation of the jurisdiction's due process procedures for persons subject to an isolation/quarantine order.[302]

An important element of legal preparedness is ensuring that court orders can be enforced. This may require police assistance.

The enforcement of public health orders involves police work different from the day to day experience of most officers. The orders arise from the opinions, beliefs and knowledge of medical professionals with expertise that police officers are unlikely to share. Police officers may face unfamiliar risks of infection without adequate information on how to protect themselves. In one case police officers were sent to apprehend an un-cooperative tuberculosis patient who was refusing medication and had a habit of spitting at persons in authority. The Police were not told that he had an infectious disease and they were not provided with the requisite personal protective equipment.

In the worst case scenario, police may face the prospect of trying to control large numbers of citizens who may balk at following certain public health orders. A study by a U.S. law enforcement think tank, the Police Executive Research Forum, highlights the insurmountable problem, and disturbing consequences, of trying to enforce the unenforceable:

> One person or a small number of persons can be restricted by force. As the number of affected persons increases, the efficacy of force diminishes because it is impossible to force a large number of persons, spread over a large area, to comply with restrictive orders. People must be convinced that the restrictions are for the public good and that they should comply with them voluntarily. The vast majority of the population will behave responsibly if they have confidence in public authorities and are properly informed. The role of the police then becomes one of facilitation of proper behavior and the management of non-complying individuals.[303]

SARS demonstrated the potential difficulties of police involvement in public health emergencies. Dr. Bonnie Henry reported that Toronto Public Health received exemplary cooperation from police in Toronto, but some other local units had a different experience:

> … the Toronto Police Service was extremely helpful to us. As a matter of fact, when the outbreak happened in Toronto, the deputy police chief said,

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[302] *Ibid.*

[303] Police Executive Research Forum, *Quarantine and Police Powers: The Role of Law Enforcement in a Biomedical Crisis* (Washington, D.C.: January 2004), p. 12.

> "What can we do to help?" That is, I think, a monumental change in attitude, and we are probably the only jurisdiction in Ontario where that happened. Certainly in some of our neighbouring jurisdictions, police said, "We have no role in this."[304]

A public health lawyer for a neighbouring region had a different experience:

> Although the section 35 order authorizes police to [do] all things reasonable to locate, apprehend and deliver the person subject to the section 35 order to the hospital or facility, police are reluctant to become involved in a "health matter."
>
> For example, we were involved in an incident where police attempted to apprehend a person pursuant to a section 35 order on three occasions but were unsuccessful. Thereafter, the board of health used a public health inspector to undertake surveillance given the police indicated that this was a "health matter" as opposed to a "criminal matter," that they had insufficient resources and would simply "red flag" the address.
>
> This public health inspector was required to follow the person subject to the section 35 order when the person left the residence and to telephone police to apprehend the person pursuant to the section 35 order. A board of health does not have the expertise or the staff to undertake surveillance.

This shows that legal preparedness requires prior consultation, planning, training, and protocols between public health and police.

Dr. Bonnie Henry pointed out the importance of this prior consultation and planning;

> I work for Toronto Public Health, but part of my job is coordinating very closely with our police, fire, EMS, and our office of emergency management … We've certainly had the discussions on a number of occasions. One of the things that our relationship has fostered is the ability to understand each other's roles a bit better … Developing those relationships and understanding where each other's authority and responsibility lie makes a huge difference in allowing you to respond in a coordinated manner.[305]

Legal preparedness requires cooperation between jurisdictions. As the Centers for Disease Control and Prevention advises:

> It is possible for federal, [provincial], and local health authorities simultaneously to have separate but concurrent legal quarantine power in a particular situation (e.g., an arriving aircraft at a large city airport).

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[304] Justice Policy Committee, Public Hearings, August 18, 2004, p. 152.

[305] Justice Policy Committee, Public Hearings, August 18, 2004, p. 148.

> Furthermore, public health officials at the federal, [provincial], and local level may occasionally seek the assistance of their respective counterparts, e.g., law enforcement, to assist in the enforcement of a public health order. Public health officers should therefore be familiar with the roles and responsibilities of other jurisdictions: vertically (local, [provincial], federal), horizontally (public health, law enforcement, emergency management, and health care), and in geographical clusters (overlapping neighbors).[306]

SARS demonstrated the importance of all these aspects of legal preparedness. The Commission therefore recommends that legal preparedness be an integral component of all public health emergency plans.

Recommendation

The Commission therefore recommends that:

- **Legal preparedness be an integral component of all public health emergency plans.**

Conclusion

Confusion and uncertainty are the only common threads throughout the legal procedures now provided by the *Health Protection and Promotion Act* for public health enforcement and remedies. Uncertainty as to which court to use. Uncertainty as to when notice is required and how to dispense with it when necessary. Confusion as to the procedural authority for orders and their degree of permanence. Uncertainty as to the procedure to amend orders to suit the circumstances. Confusion as to the authority and the procedure to obtain an interim *ex parte* order (a temporary order made in the absence of the person against whom the order is sought, to be followed by a court hearing) and the duration of such an order. Uncertainty as to the process by which the exclusion of the public from a hearing may be challenged.

Public health officials and the lawyers who advise them require not only the clear authority to act in the face of public health risks, they require also a simple, rational, effective and fair set of procedures to enforce compliance and to provide legal remedies for those who challenge orders made against them. Delays in legal enforcement may cost lives. Delays in legal remedies may put individual liberty at risk. The above recommendations are necessary to secure effective access to enforcement and to remedies.

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[306] Centers for Disease Control and Prevention, "Fact Sheet: Practical Steps for SARS Legal Preparedness," January 8, 2004.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to eliminate the complex appeal process, rife with delay, in respect of an appeal by the subject of an order from a decision of the Health Services Appeal and Review Board, and provide an appeal as of right directly to the Court of Appeal with no prior requirement to secure leave to appeal.**

- **The Ministry of Health and Long-Term Care consider whether the Health Services Appeal and Review Board is a necessary step in the complex hearing and review process in the *Health Protection and Promotion Act* or whether some other system should be enacted.**

- **The *Health Protection and Promotion Act* be amended to simplify the complex and restrictive appeal process in respect of appeals from provincial court to the Superior Court and then to the Court of Appeal but only if a judge of the Court of Appeal grants leave to appeal on special grounds on a question of law alone. This process could be simplified by eliminating the intermediate appeal to the Superior court and the restricted leave to appeal to the Court of Appeal or both.**

- **The multiplicity of procedures in respect of the enforcement of Orders made under Part IV (communicable diseases) and Part VII (administration) of the *Health Protection and Promotion Act*, be replaced by a single, simple, codified procedure in the Superior Court.**

- **The *Health Protection and Promotion Act* be amended to provide the Superior Court, when ordering compliance with a public health obligation, with a full range of remedial power, including the power to make mandatory orders.**

- **The *Health Protection and Promotion Act* be amended to consolidate and codify all provisions in respect of court enforcement and access to judicial remedies in respect of communicable diseases into one seamless system or powers and procedures.**

- **The *Health Protection and Promotion Act* be amended to include special procedures such as *ex parte* procedures for interim and temporary orders, video and audio hearings, and other measures to prevent the court process from becoming a vector of infection.**

- The *Rules of Civil Procedure* be amended to include a clear, self-contained and complete code of procedure for public health enforcement and remedies in respect of communicable diseases.

- A consequential amendment to the *Courts of Justice Act* provide that proceedings in respect of the *Health Protection and Promotion Act* enforcement and remedies in respect of communicable diseases shall be heard at the earliest opportunity.

- The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found, and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.

- The judiciary be asked to establish court access protocols in consultation with the public health legal community.

- The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be fond, and the police service shall to all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.

- The Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General, together with public health officials, establish protocols and plans for the enforcement of orders under the *Health Protection and Promotion Act* and the involvement of police officers in that process.

- Legal preparedness be an integral component of all public health emergency plans.

10. Public Health Resources

SARS showed that Ontario's public health system is broken and needs to be fixed. Evidence of its inadequacy was presented in the Naylor Report, the Walker Report, and the Commission's first interim report.

Since then, as set out in Appendix C, much progress has been made. The government has moved forward by appointing Dr. Sheela Basrur as the new Chief Medical Officer of Health, making legislative changes, and beginning to allocate resources. But despite a promising start, much more remains to be done. After long periods of neglect, inadequate resources and poor leadership, it will take years of sustained funding and resources to correct the damage. Like a large ship, a public health system, especially one as big and complex as Ontario's, cannot turn on a dime.

There is wide agreement on what still needs to be accomplished. But it takes unflagging commitment and determination to rebuild a broken public health system. Without a sustained commitment to fund the necessary changes, much that has been done will wither away and much that is urgently required will never be realized.

SARS focused on the need for public health to do more to protect us against disease, more by way of planning against threats like pandemic influenza, and more by way of increased powers for public health authorities to monitor infectious threats in the community and in health care institutions. It demonstrated that more public health resources are required in many areas, including:

- Laboratory capacity, expertise and personnel;
- Scientific advisory capacity and capabilities;
- Epidemiological expertise;
- Surge capacity;
- Infectious disease expertise and personnel;
- Strengthening public health human resources; and
- Infectious disease information systems.

Naylor, Walker, and this Commission recommended more public health resources to prevent infectious outbreaks before they erupt, and to control them once they start. The government has accepted in principle this need. The problem is that new leadership, legislative changes, reviews and new programmes require continued funding. This underlying need for sustained levels of resources was described by Dr. Donald Low before the Justice Policy Committee:

> A clear authority, I think, is number one, as you've heard, and critical; and not only having a clear authority but the resources to back that up. If you don't have those resources, then you really can't take advantage of that authority. Finally, being able to draw on the expertise to support you, whether that expertise comes locally, nationally or from other countries, is critical, especially in a setting such as SARS or pandemic influenza. The problem with dealing with these outbreaks is the sustainability of them. We can handle it for a week, but we can't handle it for two, three, six weeks. We need the expertise.[307]

Some resources have already been allocated to improve the health care system. The Ministry of Health and Long-Term Care, for example, has pledged to implement a federally-funded outbreak management system called the Integrated Public Health Information System or iPHIS. Full deployment in all public health units is expected to be completed by the end of 2005. In another example, the Ministry is creating a permanent central expert body, the Provincial Infectious Disease Advisory Committee, to continue the development of standards and guidelines for health professionals and organizations faced with infectious disease outbreaks.

This is a commendable start, but these measures mark merely the end of the beginning of the effort to fix the public health system. The end will not be reached until Ontario has a public health system with the necessary resources, expertise and capabilities, and this will take years to achieve. The U.S. General Accounting Office, the equivalent of the Auditor General of Canada, has noted that fundamental changes in large institutions can take at least five to seven years:

> … change is necessarily a long-term undertaking, requiring leadership and commitment. Experience shows that successful major change management initiatives in large private and public sector organizations can often take at least 5 to 7 years. This length of time and the frequent turnover of political leadership … have often made it difficult to obtain the sustained and inspired attention to make needed changes.[308]

The difficulty of effecting change over such a long time-line, and the importance of continuing to provide resources to sustain such profound and long-term change, is best exemplified by the problems faced by the Public Health Division in trying to revitalize the Central Public Health Laboratory.

Located in Toronto, the Central Public Health Laboratory is the Ministry of Health and Long-Term Care's key provider of diagnostic microbiology testing. As such, it is supposed to be the primary laboratory in the province supporting outbreak management and control efforts. During an infectious disease outbreak, epidemiologists and clinicians rely on laboratory tests to verify diagnoses, identify the nature and characteristics of the infectious agent, map the extent of an outbreak and gauge the effectiveness of counter-measures. These tests must be completed quickly and efficiently, and the results conveyed to those managing the response to the outbreak in a timely manner.

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[307] Justice Policy Committee, Public Hearings, August 18, 2004, p 156.

[308] U.S. General Accounting Office, Centres for Disease Control and Prevention: Agency Leadership Taking Steps to Improve Management and Planning, but Challenges Remain, (Washington, D.C.: January 2004), pp. 2-3.

But, as noted in the SARS Commission's first interim report, the provincial laboratory failed to discharge its responsibilities effectively during SARS. The Commission's first interim report stated:

> The capacity of a laboratory system to respond to an outbreak of infectious disease must pre-exist any future outbreak because it is impossible to create it during an outbreak. The functions performed by public health laboratories require the work of highly skilled professionals. This work cannot be done by recruiting inexperienced volunteers during an emergency. Nor is it adequate to rely on the hope that private and hospital laboratories will have the extra capacity when needed. Laboratory capacity is much like the rest of public health; its importance is not appreciated, nor the impact of its inadequacies felt, until there is an outbreak and then it is too late.[309]

The Naylor Report noted:

> With the provincial lab overwhelmed, some hospitals sent specimens directly to the National Microbiology Laboratory [in Winnipeg] bypassing the usual hierarchy of referral. The Hospital for Sick Children, Mount Sinai and Sunnybrook and Women's had strong polymerase chain reaction [PCR] technology – an elegant laboratory testing modality that identifies micro-organisms. They became the de facto and unfunded referral centres for Toronto SARS testing.[310]

Of particular concern during SARS was the lack of sufficient scientific expertise. When SARS hit, there were only two medical microbiologists employed by the provincial labs. All the PhD level scientists had been laid off two years earlier.

The professional inadequacy of our public health laboratory system during SARS illustrated dramatically the urgent need for sustained resources, without which Ontario will continue to be unprepared for the next outbreak of infectious disease. The sad plight of the public health laboratories provides a cautionary example of what happens when inadequate resources are allocated on a continuing basis to vital elements in our protection against infectious disease.

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[309] Commission's first interim report, p. 96.

[310] Naylor Report, p. 33.

When the Walker Panel recommended in April 2004 that the Ministry begin establishing a Health Protection and Promotion Agency, it recommended that the Central Public Health Laboratory be one of its core components. The Walker Panel stated:

> The ability to provide timely and accurate lab information to those involved in structuring the province's epidemiologic analysis and overseeing the surveillance efforts is key to an effective surveillance system and to a responsive public health system.

In its interim report, the Panel highlighted the need to align the public health laboratory system and the epidemiological and surveillance functions. The Panel also called for immediate short-term action to address the significant shortage of microbiology expertise and medical leadership at the existing Central Public Health Laboratory:

> In looking to the future, the Panel strongly suggests that the province aims to co-locate a revitalized Central Public Health Laboratory with the Agency. This will involve new lab capacity being built over time; Ontario should vigorously pursue this in addition to federal support to assist in it being realized. The Panel also believes that there are tremendous opportunities to develop formalized and much closer linkages between the central laboratory and the laboratory infrastructure at major academic health sciences centres in Ontario. The Ministry should actively seek to retain the focus and vision of the Public Health Laboratory while ensuring that it is part of a formal, broader critical mass of expertise through the appropriate partnerships with lab networks at the federal and provincial levels. A clear hallmark of the effectiveness of the B.C. and Quebec agencies is the co-location of laboratory expertise within the agency structures. Co-location allows for rapid on-site review of emergent issues, and ensures that the perspective of those involved in the testing and laboratory analysis components of surveillance and response are integrally and directly linked to the efforts of an overall team.[311]

The SARS Commission endorsed this thoughtful recommendation, which the Government accepted in June 2004, when it released *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario.* This document stated:

> Central to the establishment of the Agency is the modernization of Ontario's Central Public Health Laboratory and the public health laboratory system … The Agency Implementation Task Force will also guide an operational review of the public health laboratory system to align the available testing services with what is required. This will also help determine the functional and procedural enhancements needed to ensure that the system performs at optimal levels on a daily basis as well as during an outbreak. This review will be completed over the next few months. Formal linkages are already being

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[311] The Walker Interim Report, p. 97

> strengthened and technological infrastructure has recently been created within the Ministry and the Central Public Health Laboratory to improve communication and information exchange.
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> Our goal is to ensure a state-of-the-art public health laboratory system in Ontario. In order to strengthen the province's laboratory capacity and to prepare for co-locating appropriate functions of the Central Public Health Laboratory with the Agency, we will enhance the medical capacity of the public health laboratory system, beginning with the addition of a senior medical director and additional medical microbiologists.[312]

Achieving this important goal is no easy matter. The Public Health Division is in the unenviable position of rebuilding a critical institution in the midst of trying to implement short-term solutions to endemic systemic problems. It is like trying to build a new dike while, at the same time, shoring up a crumbling barrier of sand bags.

Take the problem of the lack of professional expertise. While the government has approved recruiting six medical microbiologists and a medical director, and recruitment is well under way, it is difficult and time-consuming to attract the best people to an organization without a record of excellence and, until now, a lack of commitment to excellence. Adding to the difficulty is the fact that medical microbiologists are in high demand across North America. As one official told the Commission:

> It's a seller's market.

For such a critical institution as the Central Public Health Laboratory, a recruitment misstep could have long-term consequences

While rebuilding the Central Public Health Lab's professional expertise, the Public Health Division is also facing a more immediate and critical need to keep the Central Public Health Lab functioning. Since SARS, one of the provincial laboratory's two medical microbiologists has left for another position and has not been replaced, and the second microbiologist is on leave. Luckily for the province, Dr. Donald Low, whose spirit of public service during SARS is to be commended, has once again stepped up and has arranged on a temporary basis for a team of microbiologists from Mount Sinai Hospital in Toronto to fill the gap.

Adding to this difficult balancing act, the Public Health Division is also in the process of commissioning experts to conduct a capacity review of the public health laboratory system and determining how it can be effectively integrated into the new Ontario Health Protection and Promotion Agency. Again, this needs to be undertaken with care and prudence, and it takes time.

The reality is, for all the Public Health Division's commendable efforts, and Dr. Low's exemplary assistance, the Central Public Health Lab remains in a difficult state. This is critical when one considers the possible threat of an influenza pandemic and the important role expected of the Central Public Health Lab. As stated in the Ontario Health Pandemic Influenza Plan:

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[312] *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario*, p. 13

> Ontario must have the ability to identify a new strain of influenza virus quickly (prompt identification increases the lead time to develop a vaccine and implement management measures) and to track virus activity. To effectively prepare for and monitor pandemic influenza activity, Ontario must have a rapid, accurate surveillance system, which includes:
>
> - laboratory or virologic surveillance (i.e., isolating and analyzing influenza viruses for their antigenic and genetic properties, definitively diagnosing influenza). This activity is essential to monitor the antigenic drift and shift of influenza viruses circulating among humans. Because the signs and symptoms of influenza are similar to those caused by other respiratory pathogens, laboratory testing is required to definitively diagnose influenza …[313]

Having regard to the continuing issues faced by the Central Public Health Lab, the Commission recommends, in an effort to mitigate its continuing problems, that it be transferred temporarily to the control of the Chief Medical Officer of Health until it can be integrated into the new Ontario Health Protection and Promotion Agency. Now housed in an area of the Ministry completely separate from the Chief Medical Officer of Health, the Central Public Health Laboratory needs to be under the direction of the Chief Medical Officer of Health to ensure unified leadership and administration of activities that bear directly on our protection against infectious disease.

To its credit, the government recognizes that fixing public health must be done over a period of years. In June 2004, two months after the release of the Commission's first interim report and of the Walker panel's final report, the government unveiled Operation Health Protection, a three-year plan to fix the weaknesses in the public health system exposed by SARS.

Despite a good beginning, some of the biggest spending lies ahead:

- Establishing the new Ontario Health Protection and Promotion Agency;
- Implementing recommendations of the assessment of the public health laboratory system;
- Integrating the public health laboratory into the new Agency;
- Implementing the recommendations of Capacity Review Committee of local public health;

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[313] Ministry of Health and Long-Term Care, *Ontario Health Pandemic Influenza Plan* (May 2004), p. 27

- Revitalizing the Public Health Division;
- Increasing the provincial share of local public health funding from the current 55 per cent to 75 per cent by January 1, 2007; and
- Funding the increased levels of monitoring, auditing and enforcement outlined in chapter 3 (Municipal Role) of this report.

While many commendable initiatives have been undertaken, a considerable number involve studies, reviews, assessments and planning: a task force to help design and develop the new Ontario Health Protection and Promotion Agency is to make its final recommendations by the fall of 2005; a review on revitalizing the Central Public Health Laboratory and integrating it into the Agency is under way; and a Capacity Review of local public health is to be completed by year's end.

This is not to say that task forces and review committees are unimportant. They are vitally important. Fixing the public health system cannot and should not be done in haste or without care. The point is that it is easier to commit massive funds to a task force than to massive expenditures recommended by a task force. The proof of commitment comes not when the task force is launched, but when its recommendations are ripe for implementation and expenditure.

As the province moves into the latter stages of Operation Health Protection, stages when significant funding will be required, the challenge will be to provide the necessary resources to sustain the momentum for change despite the government's other budgetary pressures.

The point has to be made again and again that resources are essential to give effect to public health reform. Without additional resources, new leadership and new powers will do no good. To give the Chief Medical Officer of Health a new mandate without new resources is to make her powerless to effect the promised changes. As one thoughtful observer told the Commission:

> The worst-case scenario is basically to get the obligation to do this and not get the resources to do it. Then the Chief Medical Officer of Health would have a legal duty that she can't exercise.

To arm the public health system with more powers and duties without the necessary resources is to mislead the public and to leave Ontario vulnerable to outbreaks like SARS.

11. Emergency Legislation

Introduction

The first goal of public health emergency management is to stop emergencies before they start by preventing the spread of disease. If a small outbreak is prevented or contained, the draconian legal powers available to fight a full-blown emergency will not be needed.

This is why the Commission in the previous 10 chapters has gone into such detail about strengthening the *Health Protection and Promotion Act* with workable daily powers that can prevent emergencies.

Preparedness and prevention backed up by enhanced daily public health powers are the best protection against public health emergencies.

Legal powers by themselves are false hopes in times of public crisis.[314] In the face of impending disaster no law will work without public cooperation and individual sacrifice of the kind demonstrated by so many during SARS. Without machinery to support public cooperation, emergency powers will be of little use.

Some emergencies, however, will require extraordinary action beyond ordinary government intervention and ordinary government power. Emergencies will come upon us suddenly and without warning, no matter how prepared and vigilant we may be. Any emergency, once it gets going, may overwhelm the protection provided by existing legal powers.

Ontario got through SARS without any explicit emergency legal powers. Ontario's *Emergency Management Act*, then as now, conferred no special powers to be used in any kind of emergency. SARS showed that explicit emergency powers are required to protect the public from even more catastrophic public health disasters such as the next influenza pandemic, thought by some scientists to be overdue.

Such a colossal epidemic would require strong explicit emergency powers of the kind that were not legally available during SARS.

Another reason why explicit emergency powers would be required for pandemic influenza is the uncertainty about the legal extent of existing emergency powers. Many of the actions taken to fight SARS were done without explicit statutory authority. The legal authority for every governmental action taken during SARS may be legally defended on a generous reading of existing inherent and statutory powers, but the extent of our present legal emergency authority is far from clear. Many who complied willingly with emergency directives during SARS have since then, on reflection, expressed concern that they might not do so again unless the power to issue directives and orders is spelled out clearly in some form of explicit emergency legislation.

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[314] Paraphrased from Mr. Justice Learned Hand's 1944 address *The Spirit of Liberty*.

The Commission has recommended strengthening the *Health Protection and Promotion Act* with daily powers that can be exercised with or without a declared emergency. These recommended powers include warrantless entry of dwelling houses in urgent situations but subject to a later court hearing, and subject also to court hearing, temporary detention and decontamination of people exposed to infectious agents such as anthrax or weaponized smallpox.

The special powers advocated for public health emergencies such as pandemic influenza include such measures as mass compulsory vaccination, compulsory requisition of supplies such as vaccines and respirators, compulsory closing of hospitals and other institutions, involuntary transfer of patients, and a wide range of general powers such as evacuation and rationing. These emergency powers cannot be met by the *Health Protection and Promotion Act.* Explicit emergency powers are required in addition to the daily powers now available under the *Health Protection and Promotion Act* and the further daily powers recommended by the Commission.

Public health emergencies are in many ways unique and unlike typical disasters like floods, fires, power blackouts, or ice storms. In floods and power losses people can take certain protective actions on their own. However, they have few personal defences against an invisible virus that can kill them. They must turn to trusted medical leadership.

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health, free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to doctors, not to politicians or government managers. It is essential that the public get from the Chief Medical Officer of Health the facts about infectious risks to the public health and the degree that precautions are needed and advice on how they can avoid infection. It is essential when public precautions are relaxed, like the removal of protective N95 respirators in hospitals, the re-opening of hospitals or the declaration that it is business as usual in the health system, that these decisions are made and are seen to be made by and on the advice of the independent Chief Medical Officer of Health. In a public health emergency, or the public health aspects of an emergency such as flood-borne disease, the Chief Medical Officer of Health should be the public face of public communication from the government.

It is artificial to try to distinguish between public health emergencies and general emergencies. Indeed there is no such thing as a pure public health emergency. Every big public health emergency creates problems beyond the realm of public health. Schools, jails, homeless shelters, tourism, travel restrictions, and the economy are not typically within the expertise of medical advisors. If medical predictions are correct, the next influenza pandemic will start as a public health emergency, and rapidly snowball into a general emergency.

Conversely there is no such thing as a pure general emergency. Big general emergencies that arise outside the field of public health will usually have a public health component. A major flood might bring disease through infected water. The breakdown of sanitation would soon involve public health, as would a power blackout that spoiled restaurant food.

Because there is no clear line between public health emergencies and general emergencies it would be wrong to introduce separate, freestanding, parallel emergency regimes, one for public health emergencies and the other for all other big emergencies. The existence of two parallel regimes would bring nothing but legal confusion and administrative disorder, two things no one wants in any emergency.

The government has expressed its intention to proceed with general emergency legislation along the lines suggested in Bill 138, an Act to amend the *Emergency Management Act* and the *Employment Standards Act, 2000*, which received first reading on November 1, 2004 as a private member's bill produced by the Standing Committee on Justice Policy after public hearings.

The Commission's mandate does not cover general emergency legislation for war, famine, flood, ice storms and power blackouts and the government decision to proceed with Bill 138 is not within the Commission's terms of reference. Because the government has chosen Bill 138 as the vehicle for all emergency legislation including public health emergency legislation, the Commission must say something about Bill 138 as a vehicle for public health emergency powers.

Bill 138 gives government officials unrestricted authority to override virtually every other Ontario law that gets in the way of any power they consider necessary to exercise in an emergency. It represents a profound change in our legal structure and raises issues that must be addressed whenever a statute is proposed that so fundamentally alters our system of government by law.

Every emergency power, once conferred, "lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need."[315] This danger of overreaction is accompanied by the danger of underreaction, not doing enough in the face of an uncertain and ambiguous new disease threat.

This report is interim, not final. It is written now to respond to current government plans to amend the *Health Protection and Promotion Act* and the *Emergency Management Act*. Because of its interim nature the report takes no final position on every issue around emergency powers. This chapter identifies issues such as compulsory mass immunization where further examination of the evidence may be required before the right balance can be achieved between public protection and personal rights. It also identifies issues that have not been fully confronted.

On Bill 138's impacts on public health emergencies, the Commission in this chapter notes the need for:

- A fundamental legal and constitutional overhaul of the proposed legislation by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements;

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[315] Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the race-based internment of Japanese Americans during WW II.

- Specific provisions to ensure Chief Medical Officer of Health leadership in every public health aspect of every emergency;
- A process to ensure that the general powers of Bill 138 cover all authority needed for public health aspects of emergencies; and
- A fundamental review to cover all these legal and operational aspects, a review of the kind exemplified in the Commission's analysis of compulsory mass immunization.

The various aspects of emergency legislation examined by the Commission in this chapter are found under the following headings:

- Voluntary Compliance
- Prevention, Preparedness and Cooperation
- Who's in Charge?
- Types of Emergencies
- Emergency Legislation: Two Models
- Emergency Response: Inherent Dangers
- Role of the Chief Medical Officer of Health
- Specific Public Health Emergency Powers
- Compulsory Mass Immunization: a Paradigm
- Bill 138
    - Power to Override Ontario Laws
    - Trigger, Criteria and Limitations
    - Power to Implement Emergency Plans
    - Basket Clause
    - Occupational Health and Safety
    - The Problem of Concurrent Powers

- Summary of Recommendations

Voluntary Compliance

Voluntary compliance is the bedrock of any emergency response. Even the most exquisite emergency powers will never work unless the public cooperates.

Legal powers are false hopes during a public crisis.[316] No law will work during a disaster without the public cooperation and individual sacrifice shown during SARS. Nor will any law work without the machinery that supports and compensates those who sacrifice for the greater good of public health.

Voluntary compliance also depends on public trust in those managing the emergency and public confidence that medical decisions are made on medical evidence, not on grounds of political expediency or bureaucratic convenience. The latter issue is addressed below in the context of the emergency role of the Chief Medical Officer of Health.

It is essential in any emergency to compensate those who suffer an unfair burden of personal cost for cooperating in public health measures like quarantine.

While Ontario enjoyed high levels of quarantine compliance during SARS, it is vital that this not lead to complacency. SARS revealed obstacles to compliance that may, if not adequately addressed, hamper the response to future public health emergencies. In its interviews, telephone polls and focus groups, the U.S. study on the elements of voluntary compliance referred to above identified these impediments to compliance:

- Fear of loss of income;
- Poor logistical support;
- Psychological stress;
- Spotty monitoring of compliance;
- Inconsistencies in the application of quarantine measures between various jurisdictions; and
- Problems with public communications.[317]

Fear of loss of income topped the list of concerns:

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[316] Paraphrased from Mr. Justice Learned Hand's 1944 address *The Spirit of Liberty*.

[317] DiGiovanni, Clete, Conley, Jerome, Chiu, Daniel and Zaborski, Jason, "Factors Influencing Compliance with Quarantine in Toronto During the 2003 SARS Outbreak." Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, pp. 267-70.

> Fear of loss of income was of paramount importance. It was especially significant, according to our interviews, focus groups, and Healthcare Workers Survey, for people who were unconvinced that their quarantine was necessary. This fear was the most common reason given to us for noncompliance or non-self-quarantine among people who were advised that they met quarantine criteria. And the fear was justified. Although some employers assured their employees at the outset that their pay would continue while they were in quarantine, others said it would not. The situation was even more disconcerting for those whose income came from part-time work, casual work, or self-employment.[318]

Despite criticism that it took too long to bring forward an appropriate SARS compensation package, some observers suggest that the compensation system once in place was largely responsible for the success of the voluntary quarantine programme. Dr. James Young said:

> During SARS, we were using quarantine for the first time in 50 years. One of the important things in using quarantine was getting people to abide by it. One of the important ways of getting people to abide by it was by offering financial compensation so they would in fact abide by it and stay in quarantine if and when they were ordered by the medical officer of health. We got approval from the Ontario government to institute a quarantine program and to pay people for that. That resulted in us being able to manage the quarantine in an effective manner.[319]

A lesson from SARS is that advance planning for health emergency compensation is vital. It is impossible to predict in advance the precise form and amount of compensation necessary and affordable for every conceivable emergency. It is possible to require by legislation that every government emergency plan include a basic blueprint for the most predictable type of compensation packages.

Recommendation

The Commission therefore recommends that:

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

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[318] *Ibid*, pp. 267-68.

[319] Justice Policy Committee, Public Hearings, August 3, 2004, p. 10.

Prevention, Preparedness and Cooperation

Without preparedness, emergency powers are of little use. Systems that prevent little problems from becoming big emergencies are much more important than the legal details of the emergency powers. If put in place before an emergency arises, they reduce the need to use draconian emergency powers. These systems ensure adequate planning and training and include coordinated incident management, secure sources of supply for medical and protective equipment and effective public communications.

The importance of public health emergency planning is stressed in the above chapter on medical leadership. It is essential as recommended above that the Chief Medical Officer of Health be in charge of provincial public health emergency planning; the medical officer of health on the local emergency planning level. These responsibilities should be crystallized in mandatory standards under the *Health Promotion and Protection Act*. Legal preparedness should be an essential part of every emergency plan, as should public health risk communication by the Chief Medical Officer of Health and the local medical officer of health.

It is not enough to be prepared generally or to develop "one size fits all" general emergency plans. An emergency plan for an ice storm will be of no use in an influenza pandemic. An influenza pandemic plan will be of no use in an ice storm. Specific emergency plans are required for specific threats. Generic plans are not enough.

Dr. James Young told the Justice Policy Committee that specific plans are needed to address specific risks:

> … we have come to learn that preparedness and response alone will not do it. As SARS illustrated … when an emergency happens, I can only deal with the system that's already built. I have to make that system work. I have to design other infrastructure around it, and other ways of managing. That means, then, that we're going to have bigger calamities and more problems if we start doing it at that point in time. The real work needs to be done in advance so that we can minimize the effect.
>
> We've come to recognize that a generic set of plans, a single binderful that will manage every emergency in Ontario, is not the way to go. We have to do risk-based plans. We have to figure out what the risks are in communities and to provincial ministries, and then we have to do specific planning for those risks.[320]

Measures resulting from advance planning require resources of people and equipment. Examples are surge capacity for human resources and medical equipment such as N95 respirators, gloves, gowns, visors and other protective equipment, and a secure source of supply and an effective logistical system to distribute them.

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[320] *Ibid*, p. 9

Every emergency power, such as the power to ration food, vaccines and antiviral medicines, should be supported by such systems.

The provincial response to emergencies in Ontario is structured on the incident management system, an approach pioneered by forest fire managers in California in the 1970s that has become widely accepted in Canada and the United States.

> The Incident Management System (IMS) is an international emergency protocol adopted by Emergency Measures Ontario as the operational framework for emergency management for government, and is being introduced at the local level. To ensure consistency, MOHLTC has adopted the IMS system, which will be activated once a health emergency is declared.[321]

The Johns Hopkins and Red Cross-Red Crescent Public Health Guide for Emergencies details the history of the incident management system:

> In the 1970s, after a severe wildfire season, fire managers in California (on the west coast of the United States) realized they needed a new approach to emergency response. In incident after incident, they ran into the same overall problem – poor inter-agency co-ordination. Most agencies are experienced in responding to routine or small-scale incidents. This usually involves only a few agencies and the demand for resources is limited. As disasters intensify, more agencies arrive on the scene. This brings further communication, logistical, and co-ordination problems, as listed below:
>
> 1. Having uncommon radio frequencies, signals, and codes – this leads to poor interagency communication.
>
> 2. Lack of common terms – when agencies did talk, they often misunderstood each other.
>
> 3. No effective or functional command system – each agency operated on the luck and personality of its leaders. In some situations, the operational effectiveness depended on which leader or chief was working that day.
>
> 4. Insufficient methods for giving out resources effectively.
>
> 5. Poorly defined ways of responding to disasters – there were no standard guidelines. How each response related to other functions depended upon individual interpretation.
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> A group of aircraft engineers agreed to help the fire managers develop a disaster management strategy for co-ordinating all agencies responding to

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[321] See *Ministry of Health and Long-Term Care Emergency Plan* at http://www.health.gov.on.ca/english/providers/program/emu/emerg_prep/emerg_plan.html.

> large-scale emergencies such as wild-land fires. As a result, the modern Incident Command System (ICS) was developed. It was based on the "*systems approach*" common to the defence and aerospace industries.
>
> Over the next two decades, ICS teams were only organized for wild-land fire fighting. Later, people in other emergency response sectors began to think that if ICS teams could handle a major wild-land fire, they should also be able to apply ICS to any type of emergency or disaster, ranging from natural disasters, technological disasters, terrorism, or complex humanitarian emergencies.
>
> As a result, ICS terminology and management aspects were revised and the ICS concept was broadened to an "all-hazards" approach. The Incident Command System (ICS) became the Incident Management System (IMS) – an all-risk, all agencies, coordinated system … [322]

The incident management system is intended to bring an orderly, consistent and flexible chain of command and control within an emergency response. Dr. Young told the Justice Policy Committee:

> One of the hallmarks of what we're trying to do with response is to bring in an incident command system, so whether it's the police, fire, ambulance, the municipalities or the province, we're all organized the same way and we all use the same system. When we're sitting in the middle of an emergency, we're speaking the same language and we're managing it in the same way.[323]

In the event of an infectious disease emergency and the incident management system is activated, Dr. Sheela Basrur, Chief Medical Officer of Health, indicated that she would assume the role of incident commander and oversee the response to the emergency. She said:

> … there will be many other impacts right across the city, whether it be, "Is it safe to go on the subway system?" or "Should non-essential people stay home because we need the roads clear for the ambulances?" …
>
> So in the incident management system, if I or my designate is the incident commander, there would be a whole series of operational responses, public health responses and conceivably other responses as well. They would all be planned and carried out under a public health lead to the extent that infectious disease is the thing we're trying to get control over.[324]

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[322] The Johns Hopkins and Red Cross /Red Crescent Public Health Guide for Emergencies, (Johns Hopkins University, Baltimore, MD: 2000) pp. 10-3.

[323] Justice Policy Committee, Public Hearings, August 3, 2004, p. 9.

[324] Justice Policy Committee, Public Hearings, August 18, 2004, p. 143.

The question of management and clarity arose again and again in the concerns of those who helped pull the province through SARS and who want to make sure that the lessons so painfully learned are not forgotten and that something is done to ensure that the problems of emergency management are addressed.

Two common themes ran through many submissions to the Commission in respect of emergency management. The first was the need for clear lines of authority (who's in charge) and for clarity around roles and responsibilities (who does what). The second was the need to integrate emergency plans, for instance any provincial public health emergency plan, any local public health emergency plan, any hospital plan, and indeed every emergency plan with a public health component.

The best way to present these ideas is through the thoughtful words of those who struggled with SARS and came to realize what must be done to prepare for the next emergency.

On the question of who's in charge and who does what, the following recommendations were made to the Commission:

> Specifically there is a need for clearly defined levels of authority during an emergency health situation, such as SARS. Lack of coordination and contradicting messages between the Public Health Authority, the Ministry of Health and Long-Term Care, Ministry of Labour, and Health Canada made it very difficult to function confidently during the SARS outbreak. Clearly defining the over-riding authority in such situations would decrease confusion and allow health care workers to respond quickly and confidently.
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> We require clear legal powers and lines of authority to respond to an infectious disease or biological threat, including a need for quarantines or restrictions to travel and balanced against the need to respect individual rights …
>
> … The wording of the Act addresses the responsibilities of municipalities and Ministries, but not those of the agencies that are subordinate to Ministries, such as hospitals or health departments.
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> During a declared Provincial Emergency, a single authority should be designated for the purpose of issuing guidance to healthcare organizations. Each action communicated to healthcare organizations by this authority should be clearly labeled as to whether the action is mandatory, recommended or discretionary.
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The introduction of health emergency legislation would provide an opportunity for each of the participants to have a clear understanding of their role and to engage in the appropriate planning process. While the lack of such legislation did not prevent hospitals from responding to the SARS outbreak, we believe that the introduction of such legislation would enhance the system's ability to respond and provide greater clarity to hospitals and health care workers, which will assist them in responding to future outbreaks.

From a system-wide perspective, it is the Hospital's view that the essential components of special health emergency legislation include:

1. Clear designation of areas of responsibility as between the Provincial Ministry of Health, public health authorities, public hospitals, ambulance services and individual physicians and other health care providers;

2. Provision of authority to those so designated under item 1, so that they are able to carry out their particular responsibilities, giving particular attention to clarify hierarchical and centralized decision making powers;

3. A definition of the criteria under which the legislative enactments conferring such responsibility and the authority are to apply, and a mechanism for determining when the health emergency is over and normal operations may be resumed …

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Based on our experience during the SARS crisis, the key areas that need to be addressed, in terms of legislation for an emergency situation such as SARS, are:

- The current structure of who is ultimately accountable and authorized to manage an emergency …

… Our suggestions for improvement in these areas are:

- To legislate the creation of an emergency plan/framework that has a single point of accountability and authority to manage an emergency, i.e. one person with emergency powers to create/manage a system-wide response to the emergency. This would ensure consistency in officials' directions and messages to health providers and greater cooperation between organizations.

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The Act [the *Emergency Management Act*] does define the powers of the Premier, which may be delegated to another Minister, but little else. The lack of clear roles and a designated authority structure created confusion during the SARS outbreak and should be outlined explicitly in the Act.

Scope – It is recognized that legislation cannot provide for, nor address in any detailed manner, all conceivable emergencies, but nonetheless legislation should, in a comprehensive manner, provide for the key components of emergency management – i.e. lines of communication, containment of risk; provision of expertise and human resources; establishment of a clear chain of command.

Systemic coordination – During the SARS experience, hospitals continued to function as individual entities, yet there are system requirements that need to be coordinated in response to province-wide emergencies. Legislation must therefore clearly identify who or what entity has the authority to direct hospitals and other health care facilities and providers during an emergency; what the facilities responsibility is to this authority and who is accountable for actions taken, or conversely, for failure to act. We would further suggest that in this regard, the relationship and respective powers of the Public Health Branch and the Healthcare Programs Branch of the Ministry of Health and Long-Term Care during a provincial emergency be clearly articulated.

Clarity of role, leadership, funding envelopes, and accountability needs to be struck for all aspects of emergency planning, response, and recovery programs put in place in Ontario. Not only is it unclear who is responsible during an outbreak or emergency, but also how this authority and power is shifted when an emergency is declared (shifting from the non-emergency to emergency state). Clearly defined roles and responsibilities need to be made during the transfer …

… [We] once again re-emphasize the need for clear authority and a collaborative working relationship between all parties during an outbreak: the *EMA* does not illustrate this or emphasizes its utility. The Act sets out a generic framework. It makes no mention of specific roles for agencies and individuals. It empowers the control group to take actions within the law to control the emergency, but it does not go the further step to establish a functioning relationship between the parties. This is a key principle, especially when the health emergency is health related. The *EMA* deals with non-health related emergencies, and as witnessed in SARS (2003), it is poor in dealing with health emergencies.

> A lack of a clear delineation of authority and responsibility between jurisdictions resulted in disjointed communication, information overload, and mixed messages to clinicians.

On the question of integrating emergency plans, the following recommendations were made to the Commission:

> … no outbreak follows political boundaries. This said it has to be noted that there is little if any room in the current legislation to deal with cross boundary issues (inter-provincial, and inter-jurisdictional issues within Canada let alone International issues) that may arise during an outbreak. A prime example of this can be found in the current experience with the Pandemic Influenza planning process underway in Ontario. Jurisdictional and political "turf wars" are guiding this process, more than the betterment and protection of "the public" in general. Coupled with this issue, is the lack of acknowledgement of the differing circumstances in the rural versus urban centres in Ontario. Generic planning for "Ontario" diminishes the complexity of Ontario's society and culture – including Native issues, the multi-cultural nature of the province, global communications, and the rural urban divide, which clearly exists in the province.
>
> Repeatedly, it has been stated that what will work for Toronto, will not necessarily be sustainable or practical outside of Toronto, and this needs to be acknowledged in reforming the system. To date, there have been no clear indications that this is being done. There is a continuing lack of clarity between the activation and response functions of different levels of government. This is particularly true in counties, as distinct from regions in Ontario. In these sites, a small lower tier municipality (town or township) has an emergency program (plan, education, exercises). More recently, the upper tier county level of government has been mandated to develop an emergency program. The coordination of lower tier vs. upper tier responses is not well characterized in legislation. Healthcare providers, facilities and municipalities need practical, applied simulation exercises (e.g. table top exercises) without the need to develop these independently in all areas …
>
> … Currently townships, counties, and hospitals design, prepare and run simulations, and fund their emergency planning process through their own budgets. There is collaboration on many fronts with these various levels of governance, but emergency planning is very much an independent process. The *Emergency Management Act* does not clearly delineate what happens to this independence during an emergency and if the control of the process remains at the local/hospital level or if it is subsumed by the Chief Medical Officer of Health or provincial emergency management unit. Some greater clarification of this process needs to be developed including taking into consideration the 'health' aspects of the emergency.
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> In future, we believe the province requires a centralized command-and-control structure on a "civil defence model" for emergency situations where there is integration of federal, provincial and municipal legislation and plans. This would require strengthening and altering the *Emergency Management Act*. Lines of authority should be clearly integrated and defined across federal, provincial and municipal jurisdictions. Individual health facility emergency plans also need to be standardized and integrated into municipal plans. Training should be provided to all those in the lines of authority to ensure that the scope of their authority and responsibilities are clear, feasible and understood. We would recommend one designated lead authority and spokesperson working with subgroups in future vs. multiple leads, as was the case in 2003. Multiple leads sometimes conveyed conflicting messages at press conferences and in private consultations.
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> The wording of the Act [the *Emergency Management Act*] should provide a legal mandate and requirement for agencies which are subordinate to the Ministries, such as hospitals, to formally coordinate their planning and related activities with those of the communities in which they are located.
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> … we agree with the need for all levels of government to review their respective legislative instruments in light of the lessons learned from SARS. Moreover, we have to ensure, collectively, that the provincial/territorial and the federal legislation complement each other so as to improve the public health protection offered to Canadians.

Because these views come from organizations who worked in the front lines during SARS they are entitled to great weight and careful consideration.

The Commission therefore recommends that Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.

SARS not only underlined the importance of having an effective emergency management structure, it also emphasized the need to have sufficient quantities of medical supplies, secure supply chains and the means to distribute the supplies. While more will be said in the final report about these issues, it is relevant in this interim report for the Commission to examine certain legal questions related to public health emergency supply chain matters.

Many who worked through SARS told the Commission about their frustration with persistent supply chain problems.

Karen Sullivan, Executive of the Ontario Long-Term Care Association, said at the SARS Commission Public Hearings:

> Supply chain issues across the system led to shortages of equipment, N-95 masks, et cetera, that are not part of typical infection control management supplies. Coordination to ensure – to assure system-wide distribution of key emergency supplies is an important lesson.[325]

David McKinnon, past president of the Ontario Hospital Association, noted at the SARS Commission Public Hearings that supply chain management is lacking. He said major studies suggest that there should only be one supply chain management for all systems – "for all hospitals and that the technologies which underline that system should be fully contemporary so that the availability of supplies and equipment is transparent to everyone and so that we are not caught with fundamental information blockages at time of emergencies."[326]

Dr. Yoal Abells, Chair of the Family Physicians of Toronto, said at the SARS Commission Public Hearings:

> In terms of supplies and equipment, a reliable source of equipment – supplies and equipment is necessary. The just-in-time delivery system did us in. It may have looked good to the financial gurus and our hospital bean counters but it simply took too long to get supplies and equipment to the front line care worker – providers because there was a shortage of supplies and equipment. We need a reliable materials management system with immediate surge capacity.
>
> Supplies and equipment are useless without an effective distribution system.[327]

Getting enough supplies of N95 respirators was a wide-spread problem. An article in the *Lancet Infectious Diseases* by officials from Toronto's University Health Network describes the particular challenge of getting enough masks:

> … submicron filtering masks (e.g., N95 masks) were in variable supply, because before SARS such masks were used only for patients with airborne infections and hence most facilities would have only kept a limited supply. With 211 hospitals in Ontario alone requiring these supplies, Canadian suppliers rapidly ran out of stock. There was no pre-existing supply stockpile, and our mask supplies were obtained from foreign manufacturers. Because SARS was a worldwide threat, there was great difficulty in acquiring

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[325] SARS Commission, Public Hearings, October 1, 2003, p. 56.

[326] *Ibid*, p. 109.

[327] *Ibid.*

> masks from other countries, since foreign governments understandably wanted to keep such supplies for their own citizens.[328]

The Commission heard from many nurses and other health care workers, whose story will be told in the final report, about the problems they encountered with insufficient supplies such as respirators.

The importance of having emergency supplies and a secure supply chain is an important lesson as we prepare for the possibility of future public health emergencies, like pandemic influenza.

Dr. Young testified at the Commission's public hearings:

> We clearly learned lessons out of this about inventory control on the future and maintaining supplies of infectious control materials, but that, again, in the world we lived in, in those days, did not exist and we had to create those systems and create those systems for delivering supplies to doctors' offices. Those systems were simply not in place.[329]

The Walker interim report said:

> SARS thus revealed clear provincial and national weaknesses around both production and distribution of emergency supplies. The Panel is aware of work at the provincial and federal levels to upgrade stockpiles and formalize distribution networks.[330]

In January 2005, the province announced an investment of $13.5 million on emergency medical equipment. It said:

> The $13.5 million investment aims to build preparedness for chemical, biological, radiological and nuclear (CBRN) emergencies, such as nuclear-related illnesses and train derailments. It is the first investment of its kind in Ontario's history. The investment will be used to:
>
> - Purchase one portable, self-contained decontamination tent for every hospital emergency department. Tents ensure decontamination of any patients exposed to chemical, biological, radiological or nuclear (CBRN) agents occurs outside of the hospital, reducing risk to other patients and staff. Tents contain an area for stretchers, shower facilities, and can store potentially contaminated grey water from shower runoff.

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[328] Sue Lim, Tom Closson, Gillian Howard, and Michael Gardam. "Collateral damage: the unforeseen effects of emergency outbreak policies. Lancet Infectious Dis. 2004; 4(11): 697-703."

[329] SARS Commission, Public Hearings, September 29, 2003, p. 133.

[330] Walker Interim Report, p. 123.

- Build emergency stockpiles of equipment and supplies to assist hospitals in dealing with a CBRN event. These stockpiles will include:
    - gloves, masks, goggles
    - protective suits
    - hand sanitizer
    - spill control products
    - radiological/nuclear monitoring systems and air samplers
- Train hospital staff for all types of emergencies, including CBRN events.
- Enable hospitals to conduct emergency exercises in conjunction with Ontario's Emergency Medical Assistance Team and in partnership with community first responders.
- This investment will bring a consistent level of emergency preparedness across the hospital sector.[331]

Despite these important and commendable efforts and others to prepare for an emergency, one can imagine the heightened demand on emergency stockpiles and supply-chains in the event of an influenza pandemic.

The Justice Policy Committee's report recommended that hospitals be designated to receive key medical and other supplies during an emergency:

> … the government designate hospitals as priority services in municipal emergency plans to ensure priority access to water supplies, fuel, and telecommunications during an emergency.[332]

The Commission endorses this recommendation and recommends that, in the event of a public health emergency, it be extended to all front-line components of the public health response.

During a public health emergency like an influenza pandemic, the demands on medical and other necessary supplies might require strong measures to secure necessary supplies and ration them appropriately.

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[331] Canada News Wire, Operation Health Protection' Giving Hospitals Improved Training And Emergency Supplies, January 13, 2005.

[332] Justice Policy Committee, "Report on the Review of Emergency Management Law in Ontario," (Toronto: November 2004), p. 5.

Public health emergencies require legislation to address the supply chain problems addressed above. Those jurisdictions with separate public health emergency statutes address the problem specifically in terms of medical supplies. Bill 138, because it is general legislation designed to cover all emergencies, addresses the problem in general terms.

Section 7.0.2 (4) of Bill 138 contains the following emergency supply-chain powers:

> 7. The use of any necessary goods, services and resources within any part of Ontario.
>
> 8. The procurement of necessary goods, services and resources, the distribution, availability and use of necessary goods, services and resources and the establishment of centres for their distribution.
>
> 9. The fixing of prices for necessary goods, services and resources and the prohibition against charging higher prices in respect of necessary goods, services and resources than the fair market value of the necessary goods, services or resources immediately before the emergency.

These powers are unclear. They do not provide that goods and services and resources may be used or procured without consent. Words like use, procure, fix, and requisition do not necessarily imply any element of compulsory taking. They do not authorize expropriation or compulsory seizure. Other emergency statutes do make such provision.[333]

The Commission therefore recommends that Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2 (4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.

This particular example of lack of legal clarity in Bill 138 raises a general concern about its proposed powers. Is their purpose clear, and do they achieve their purpose, or do they on close examination reveal ambiguity as to their purpose and effect. The Commission therefore recommends that all the powers proposed in Bill 138 be reviewed by the Attorney General to ensure that there is no doubt as to their intended purpose and their legal effect.

Recommendations

The Commission therefore recommends that:

- **Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.**

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[333] See, for example, New Brunswick, *Emergency Measures Act*, S.N.B. 1978, c. E-7.1, s. 13(b); Nova Scotia *Emergency Measures Act*, S.N.S. 1990, c. 8, s. 14(b); Prince Edward Island *Emergency Measures Act*, S.P.E.I., c. E-6.1, s. 11(b).

- **Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2(4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.**

- **All powers proposed in Bill 138 be examined to remove ambiguity of the sort that appears in s. 7.0.2(4) 7, 8 and 9 to ensure there is no lack of clarity as to the intended purpose and legal effect of any proposed power.**

Who's in Charge?

In times of emergency it is essential to know who is in charge. As Dr. Basrur noted in her appearance before the Justice Policy Committee:

> The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is.[334]

This interim report addresses the question of who was in charge at the public service level, not the political level.[335]

The leadership confusion and lack of clarity during SARS was at the operational and managerial level. There was no system in place to ensure one person was in charge of the overall management of the crisis and one expert medical leader to be in charge of medical issues. Lines of authority and accountability were unclear. These problems presented at the top, middle, and front line of the operational response to SARS. They resonated negatively throughout the response to SARS in the form of blurred chains of command, ambiguous reporting relationships and confusing directives and orders.

At the top it was unclear who was in charge: Dr. James Young, the then Commissioner of Public Safety and Security (a position now called the Commissioner of Emergency

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[334] Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.

[335] The Commission, as noted in the first interim report, continues to investigate the question whether public health decisions were influenced by political considerations. The Interim Report stated: "The Commission on the evidence examined thus far has found no evidence of political interference with public health decisions during the SARS crisis. There is, however, a perception among many who worked in the crisis that politics were at work in some of the public health decisions. Whatever the ultimate finding may be once the investigation is completed, the perception of political independence is equally important. A public health system must ensure public confidence that public health decisions during an outbreak are free from political motivation. The public must be assured that if there is a public health hazard the Chief Medical Officer of Health will be able to tell the public about it without going through a political filter. Visible safeguards to ensure the independence of the Chief Medical Officer of Health were absent during SARS. Machinery must be put in place to ensure the actual and apparent independence of the Chief Medical Officer of Health in decisions around outbreak management and his or her ability, when necessary, to communicate directly with the public."

Management), or Dr. Colin D'Cunha, the then Chief Medical Officer of Health. One medical leader put it this way:

> I think that if you asked me who was in charge of the SARS outbreak at a provincial level, I would have a very difficult time telling you who.

This confusion was highlighted by a submission to the Naylor committee signed by the chief executives of nine major health care groups:

> During a crisis or emergency, the public will quickly begin to look for a trusted and consistent source of information. However, during the early days of the SARS crisis, in Toronto, there were occasions when several different public health officials were being quoted and had titles attributed to them that appeared to indicate they were responding in an acting capacity only and not as an 'official.' This had the potential to leave an impression with the public that no one with any authority was in control.[336]

As noted in the Commission's first interim report, the SARS response was also hamstrung by an unwieldy emergency leadership structure with no one clearly in charge. A *de facto* arrangement whereby the Chief Medical Officer of Health of the day shared authority with the Commissioner of Public Safety and Security resulted in a lack of clarity as to their respective roles which contributed to hindering the SARS response. Compounding the problem, in the view of some observers, was that branches of the Ministry of Health and Long-Term Care appeared to function on their own. As the Naylor report said:

> … the dual leadership structure was less than ideal, and one person should have been in charge. Matters were further complicated as other branches of the MOHLTC helped to manage the interactions with hospitals, long-term care facilities, physicians, and various elements of the health service system. A number of physicians involved in caring for SARS patients began actively discussing whether and how the management of the outbreak could be handed over to a single "SARS czar".[337]

The disastrous news conference on May 23, 2003 to announce a major SARS outbreak at North York General reinforces the point that one person needs to be in charge of public communication of health risk and that the Chief Medical Officer of Health, armed with the independence recommended by the Commission and accepted by the government, should be that person.

During the news conference, a reporter initially asked Dr. D'Cunha about the situation at North York General. Dr. D'Cunha answered:

> There are a couple of people under investigation.

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[336] Naylor Report, p. 32.

[337] *Ibid*, p. 31.

Then, he turned the floor over to Dr. Low, who dropped what one reporter called "a bit of a bombshell" and announced the new outbreak:

> It's been a rough day at North York. I don't have all the answers for you tonight but what we've essentially identified is a cluster of cases that occurred on one ward at North York General … That there has been a likely transmission to health care workers. That there has been transmission to family members. And that there's probably been transmission to other patients.

After Dr. Low suggested that this cluster numbered "in the 20s," an incredulous reporter asked with justifiable heat:

> In the twenties. Okay. Why did you just go through this whole presentation for 20 minutes and we had to get it in a question? Why didn't you tell us at the start?

As noted in the Commission's first interim report, the confusion that marked the May 23 press conference exemplified the lack of any coherent communication strategy and the lack of any clear lines of accountability for the communication to the public of vital news about the status of the outbreak

Dr. Low, who had worked diligently all day to get to the bottom of a new troubling outbreak, was placed in the uncomfortable and unfair position of answering for systemic deficiencies in the uncoordinated flow of information.

The confusion that marked the May 23 press conference exemplified the lack of any coherent communications strategy and the lack of any clear lines of accountability for the communication to the public of vital news about the status of the outbreak.[338]

Tom Closson, President and CEO of the University Health Network, made this point at the Commission's public hearings:

> … during SARS, was the fact that, there wasn't enough attention given to unified communication We would see infectious diseases specialists being interviewed as being part of the POC. We'd see them being interviewed as representing their hospitals. We'd see them as being interviewed as, maybe, representing themselves and there's a lot of conflicting information going around.

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[338] Some officials in the Ministry of Health and Long-Term Care think that the Chief Medical Officer of Health should not be clearly in charge. They think it is more comforting to the public to see a small group of government officials, each talking about the crisis from their own individual perspective. The Commission rejects this perspective. If any one incident rebuts this perspective, it is the May 23 press conference, the consequent loss of confidence that anyone was really in charge, and the loss of confidence that the public was being told the whole story.

> … Fighting it out in public is not really the best way to instill confidence. I'll tell you, our staff were quite frightened during SARS because they heard different things from different people and unified communication was necessary…[339]

It is essential during an emergency that the public and those fighting the emergency know who is in charge. As noted below it is essential that the Chief Medical Officer of Health be in charge of medical decisions, medical advice, and public communication about health risk and health safety, that the Commissioner of Emergency Management be in charge of all other matters, and that their respective roles be clear. Machinery to secure clear lines of authority is discussed below.

Types of Emergencies

The introduction to this chapter notes the uniqueness of public health emergencies. An infectious disease emergency like SARS can unfold over a much longer time frame than other emergencies. It is usually characterized by unknowns and intangibles. It evokes sustained responses of fear, both reasonable and unreasonable. It generates heightened stress. And it has the potential to strain severely, over time, personal and community bonds.

With a train derailment, a tornado or the 9/11 tragedy, one knows quite clearly in the early stages of the event's unfolding that a terrible catastrophe has occurred. Public health emergencies like SARS may involve a new illness, or one radically different from known disease strains. The new illness may not even have a name. It may present symptoms quite similar to other diseases. Its lethal nature and long-term effects may be completely unknown. And, while the outbreak gathers momentum, there may be no fool-proof means of diagnosing it or identifying its victims.

Again, as noted in the introduction to this chapter, it is artificial to speak of public health emergencies as if they are distinct from general emergencies. There are no pure public health emergencies. Although pandemic influenza might start as a public health emergency, it would rapidly snowball into a general emergency. Big general emergencies that arise outside the field of public health will usually have a public health component, such as flood-borne water infection.

Public health emergencies are different because unlike forest fires, floods or tornadoes, the underlying cause of an infectious disease emergency and its progress defies efforts to locate its core, its expanding perimeter and its agents of transmission.

In short, an infectious disease emergency is not easily traceable in real time. A public health emergency can unfold over a long, complex time frame. If there is a readily discernable beginning, it may not be identifiable until well into the outbreak. In all likelihood, as occurred with SARS, there may be no easily identifiable end. To declare an end to a public health emergency is fraught with danger. Declare it over too soon and hidden reservoirs of the disease may still linger, waiting for opportunities to re-emerge.

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[339] SARS Public Hearings, October 1, 2003, p. 200.

Dr. James Young told the SARS Commission hearings:

> … it's not like a forest fire which, in and by itself, can be difficult enough to control, but if I want to know the size of a forest fire, I can get above the forest fire, see where it is and build a barrier so that the forest fire does not jump over that barrier and even if it does, I may be able to have a series of smaller fires I can put out.
>
> The theory in controlling something like SARS is the same but the difficulty and the problem is, I have no idea where it is. I only know where it was 10 days ago and I have to not only catch up that 10 days, I must get further ahead.[340]

This means that accountability and governance requirements may have to be different in a public health emergency than, say, a power outage. The uncertain time frame of a public health emergency means that the feasibility and dynamics of accountability and governance require modification from those expected in other types of emergencies.

Dr. Young has said:

> I firmly believe there must be accountability and that's the way you have to operate, but I also think you have to be careful that you don't trip over your accountability. In the middle of an emergency, there is an awful lot going on and there are a lot of ends, so if your accountability time frames are either too rigid or too short, you're going to stop what you're doing and lose focus on what you're doing just so you can go back and account. Then you're going to be accounting for why you lost your focus and why people died because you were busy producing a report to go to a Legislature or somewhere else. So I think the accountability has to be at a point in time when you have the ability and the luxury to do it and do it well and to stop and consider it. It should be on an ongoing basis but it shouldn't be so tight that it interferes with the actual management of the emergency. …
>
> I would have been quite happy in the power blackout – you know, two weeks after we're in pretty good shape and we can start to account for it. In SARS, after two weeks we were still at the height of it, and being accountable two weeks into it would have been a very major burden.
>
> The other thing, from a personal point of view, is that after you're over it, for the people who are involved in it, there's a certain level of fatigue that sets in

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[340] SARS Public Hearings, September 30, 2003, p. 35-6.

> at that point and you'll get a better accounting a little bit later, when you've had a couple of days off once in a while.
>
> The problem with accountability – and I don't know the solution; I can't give you the answer – is that it does vary to some extent. If it's an ongoing process and an ongoing emergency like SARS, the accountability needs to be further out; if it's a shorter thing, then the accountability can be sooner.[341]

Further distinguishing public health emergencies are the tools and resources required to resolve the crisis. Where other kinds of emergency responses may require heavy-equipment operators and electrical experts, resolving public health emergencies is in the hands of a relatively small cadre of skilled professionals and agencies. Containment efforts rely on the resources and capabilities of medical specialties, like infection control and epidemiology, focused on disease prevention and containment in the population. Cutting-edge epidemiological and scientific direction and advice is vital to timely containment.

The key institutions and agencies at the forefront of containing a public health emergency tend to be publicly-funded and regulated. Although there was some spread in households and doctors' offices, and a limited element of community spread, SARS was largely a hospital-spread infection. Of the 247 probable cases in Ontario 190, or 77 per cent, were either health care workers, people who sought care at health care facilities or visitors. Health care workers were the predominant group: 108 were probable cases, a full 43 per cent of all probable cases.

Public health emergencies thus engage Ontario's complex, fragmented, unwieldy health care system, with all the challenges that entails. The Toronto Public Health unit, for example, has 22 hospital corporations within its jurisdiction. Some, however, also have sites outside the City of Toronto. The Rouge Valley Health System has two sites in Toronto and three outside the city.[342]

As Dr. Bonnie Henry, formerly of Toronto Public Health, has said:

> If we are doing things differently in two different health units, that can be very difficult for a hospital.
>
> It's the same if we look at our mental health system, our community care access centres, our district health councils, our long-term-care facilities. They are all, if you want, regionalized or organized on different geo-graphical and jurisdictional boundaries. That can create massive difficulties in dealing with an emergency, and it's not limited to the health sector. It's similar in many

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[341] Justice Policy Committee, Public Hearings, August 26, 2004, p. 320.

[342] Justice Policy Committee, Public Hearings, August 18, 2004, p. 153.

> other parts of our organization as well. For example, one health unit may actually involve several different municipal police services plus the OPP.[343]

This is not to say that public health professionals are only involved in infectious disease emergencies. As noted below by Dr. Basrur they also play important albeit less directing roles in responding to emergencies where public health capabilities, expertise and resources are not the main factors in the response.

Filling the legal gaps identified by SARS requires consideration of both the primary and secondary roles of public health in crises that are not public health emergencies.

An Ontario expert whose public health experience in emergency management began in the 1970s told the Commission that there is a clear distinction between the primary and secondary emergency roles of public health professionals and agencies:

> If a nuclear plant goes down, that's a much different kind of situation. There's a health component to it immediately for anybody injured – for evacuation of people out of the area. But you're not dealing with major medical [event] on a broad scale. Just those people that were injured at the initial site or whatever – if it was a train derailment or a bomb, or whatever. That's different from a communicable disease kind of outbreak, because we're not looking at putting out a fire, or repairing a facility or cleaning a bio-hazardous material from the area – that is something that is spread through communicable disease. That's probably where it divides.

Public health emergencies have unique aspects that require expert independent medical leadership from the Chief Medical Officer of Health as described in the next section of this chapter.

As noted by one professional association:

> Prefacing this section, it must be stated that a health emergency is fundamentally different than an emergency caused by a natural disaster, or other human-initiated emergency that may have some health implications. Specific health emergency legislation is needed to draw together expertise, resources, and establish a hierarchical transfer of authority to those in the healthcare system who will have the responsibility to make informed evidence based decisions to protect the public.
>
> There is a clear and present need for special emergency health legislation in Ontario. Coupled with this, there is a need for clarification of the ownership of the health hazard and risk assessment (s 5.1.2 of the EMA) and the accountability of provincial authorities concerning CBRN, bioterrorism,

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[343] *Ibid.*

> infectious disease, etc. Embedded in this there are implications for the new *Personal Health Information Protection Act* that need to be explored.
>
> Very clear roles, responsibilities, linkages, and inter-relationships for the health agencies, facilities and professionals involved in the health emergency need to be demarcated in this legislation, as well the role of the CMOH and the local MOH in the declaration of the emergency and the roles once the declaration has been made need to be determined.

The Missouri State Emergency Management Agency describes this difference in the following terms:

> Public health emergencies can occur as primary events by themselves, or they may be secondary to another disaster or emergency, such as tornado, flood, or hazardous material incident.[344]

In her appearance before the Justice Policy Committee, Dr. Sheela Basrur made a similar observation, suggesting that in infectious disease outbreaks, the Chief Medical Officer of Health needs to lead the provincial response, but may take a more supporting role in other kinds of emergencies:

> For other emergencies, whether it's a toxic release or a radiation accident or a major flood, there may well be health implications attached to those, but it's not as clear to me that the Ministry of Health and the public health division is the lead agency for the care and control of the incident. They are absolutely going to be main supporters of the response, but not necessarily the lead. That's the distinction I would make.
>
> We can probably have a long debate, till the end of the day, about what's a public health emergency where you might have a mixture. They talk about the spectre of, let's say, a dirty bomb. A dirty bomb might be an explosive device that contains either nuclear or radioactive material, or it may have some real or perceived infectious pathogens in it. You're going to have mixed responsibilities, mixed jurisdictions. You'd have to deal with that on a case-by-case basis, and everyone is going to have to work together extremely closely anyway.[345]

At the same time, it must be kept in mind that certain emergencies can begin without a public health focus but can, depending on how events unfold, become public health emergencies. Response to an outbreak of avian flu could start with efforts to cull infected birds, protect the health and safety of workers involving in the culling and dispose of the carcasses in a manner that does not contaminate the environment. But if any humans get infected, it could become a public health emergency. If someone infected with avian flu also happened to be carrying another human virus at the same time, it could lead to the creation of a new virus that may have the ability to pass from one person to another.

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[344] State of Missouri Emergency Management Agency, *Missouri Hazard Analysis*, (Jefferson, City, Missouri: September 2003), p. P-1.

[345] Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.

As Dr. Young has warned:

> So the great risk with an avian flu is that it could turn into the new Spanish flu. We think that's how the Spanish flu started in 1918-19. Between 20 million and 50 million died of the Spanish flu at that time.[346]

Emergencies in the real world do not separate themselves into pigeonholes like general emergencies, public health emergencies, serious emergencies and catastrophic emergencies. Emergencies, by their unexpected nature and their ability to change direction suddenly, defy precise legal classification.

The argument against distinct and separate statutory regimes for different levels and types of emergencies was put very clearly by Dr. Young to the Justice Policy Committee;

> Mr. Arthurs: Could the application, the inclusion in legislation of these extraordinary powers, be in distinct legislation?
>
> Dr. Young: I would recommend against it. I think when you separate it out, you're making it – it makes more sense to me that it's part and parcel of an emergency, and I don't think it's an accident that it sits within other acts as well and not as a separate and distinct thing. If you start putting it outside and putting it separately, then you're saying, "We've got about five levels of emergencies," and I think it's very confusing.
>
> If we start and we have a provincial emergency and then on the third day I need an extraordinary power, we announce we've bumped it up and we're using an extraordinary power, and two days later I say, "We've still got an emergency, but we've bumped it down one level of emergency," what you get is the weariness and the problems the United States is having with the coding system: What does it mean and how do you manage and do I not have to pay attention now because the extraordinary powers are out? I think it just becomes potentially a management issue in running the emergency, because you've got so many levels that people are going to be arguing with you, "Well, yesterday I had to follow your direction; today I don't." So I think there are issues around it.[347]

It is simply too confusing to enact separate legislative regimes for separate and distinct levels and categories of emergencies.

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[346] Justice Policy Committee Hearings, August 3, 2004, p. 12.

[347] Justice Policy Committee, Public Hearings, August 26, 2004, p. 319.

Because public health emergencies do not confine themselves to public health problems, and because general emergencies invariably involve some component of public health emergency, and because Ontario has chosen Bill 138 as the primary legal vehicle to carry emergency action, it would not be helpful to enact a separate definition of public health emergency. Although legislation in many American jurisdictions and some other Canadian provinces[348] refers specifically to public health emergencies as distinct from other emergencies, Ontario's SARS experience suggests strongly that it is better to have one single seamless emergency response without artificial legal barriers to inter-agency cooperation. To have a separate definition and separate legal regimes for public health emergencies and other emergencies would create two separate systems when SARS showed us that it is difficult enough to coordinate a single emergency system.

The Commission's view is shared by the Ministry of Health, as indicated in a letter from the Minister to the Commission received on March 14:

> We understand that the upcoming report will focus mainly on public health and proposed amendments to the *Health Protection and Promotion Act* (*HPPA*). In addition to amendments to the *HPPA*, you have referred to powers of the Chief Medical Officer of Health in the course of a "public health emergency." While we are committed to ensuring that the Chief Medical Officer of Health has the necessary powers under HPPA to address issues as they arise under that legislation, including powers available in any emergency, and we will continue to look at how best this can be achieved, we do not feel that a separate definition of "public health emergency" per se achieves this goal in a clear manner.
>
> I, the Minister of Health and Long-Term Care, have sought the advice of the Chief Medical Officer of Health and she has expressed to me her reservations on this point, including the risk of potential confusion that could arise with dual definitions of emergency. In our view, it would be difficult to imagine an emergency that does not have some public health component or risk. Therefore, while the concept of clear roles for a CMOH in an emergency is clearly one we agree with, the manner in which this is achieved requires careful examination. We therefore look forward to reviewing your report in full and particularly your detailed comments on this matter.

For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act's* health protection powers.

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[348] See Alberta's *Public Health Act*, R.S.A. 2000, c. P-37, s. 1(hh.1); Saskatchewan's *Public Health Act, 1994*, S.S. 1994, c. P-37.1, s.2(jj.1); Manitoba's *Public Health Act*, C.C.S.M. c. P.210, ss.22.1ff; Quebec's *Public Health Act*, R.S.Q. c. S-2.2, s.118.

While SARS showed us that there should be only one emergency response system, it showed us also that medical aspects of emergency response should be directed by the Chief Medical Officer of Health for all the reasons referred to above, including medical expertise, independence, public trust, and the unique nature of the health care and public health systems. This special requirement, discussed below, will not necessitate a separate definition of public health emergency. It will however require some statutory language to ensure clarity in the respective roles of the Chief Medical Officer of Health and the Commissioner of Emergency Management. The best way to provide clarity is to give words their ordinary day to day meaning. The drafting of amendments to Bill 138 is a job for Legislative Counsel and the Crown law officers. All the Commission can do is to offer some general suggestions for elements they may wish to consider when drafting those provisions of Bill 138 that deal with the role of the Chief Medical Officer of Health in public health emergencies and the public health aspects of larger emergencies:

> "Public health" in the expressions "public health emergency" and "public health aspect of any emergency" includes any matter touching on the protection of the health of the people of Ontario from infectious disease or any other health risk including, without restricting the generality of the foregoing, public communication of health risk and safety.

This approach avoids a definition of public health emergency that creates an artificial distinction between public health emergencies and other emergencies. This approach ensures clarity as to the role of the Chief Medical Officer of Health in the public health aspects of any emergency.

Recommendation

- **For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act* health protection powers.**

Emergency Legislation: Two Models

Of the many models for emergency legislation two systems are relevant for Ontario at this time.

The first is the present model which involves three elements:

1. Specific statutory powers to deal with specific emergencies such as forest fires.

2. Inherent powers,[349] not set out in legislation, such as the power used to evacuate 218,000 Mississauga residents after the 1979 chlorine gas train derailment.

3. An *Emergency Management Act* which provides no additional emergency powers but concentrates existing powers for effective emergency deployment and provides for emergency plans.

The second is the model represented by Bill 138 which enacts broad emergency powers to make orders which override existing laws.

The case for the existing model without any special emergency powers was made in a 1981 discussion paper prepared by Solicitor General Roy McMurtry who had managed the Mississauga derailment within the framework of the existing law without any special emergency powers:

> Some persons feel that the draft Bill should grant special powers, for example, authorizing the entry of private property and the commandeering of property in an emergency. The draft Bill does not adopt this recommendation. It is felt that existing powers are adequate to deal with emergencies, both large and small. The responsible officials have the same powers when one building is threatened by fire as when one hundred buildings are threatened by fire.
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> ...
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> It is infinitely better that the courts should decide as each case arises, whether having regard to the necessities of the case the safeguards required in the public interest, the police are under legal duty in the particular circumstances."

Deputy Commissioner Maurice Pilon of the Ontario Provincial Police noted before the Justice Policy Committee that the existence of these inherent powers gives the police the authority to evacuate neighbourhoods without additional powers of the kind proposed in Bill 138. But he noted, very significantly, that it would make the work of the police easier in an emergency if their authority was set out in more legally explicit terms:

> ... on the issue of evacuation during emergencies, it's my opinion that we need not create additional powers since they exist and can be locally exercised, thereby respecting the notion of the lowest competent level of response. Having said that, in practical terms in the absence of legislation that specifically authorizes evacuation, and forcible evacuation if necessary, it sometimes becomes a very difficult issue in dealing with the residents who

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[349] It may be more technically correct to refer to these powers as ancillary powers because they are necessarily incidental to statutory powers such as those contained in the *Police Services Act*.

> choose for their own personal reasons not to leave a facility or a residence. You'll find that the elderly in particular do not wish to leave. They become confused and so on.
>
> So I would say that while we have the authority, it could be very much tested in law. It would be much easier if the law did specify that that authority existed.[350]

Before turning to the arguments for and against these two principal models, this is a convenient place to note a suggestion that there may be a third model which involves a significant judicial presence in emergency management. The *Toronto Star* in a thoughtful editorial[351] said this:

> One way to ensure the government is held to account would be to immediately refer any emergency declaration to a court to assess its legitimacy. The government could then make emergency orders pending the court's decision, but in the knowledge that its actions were being reviewed.

It is difficult in the absence of a more fully developed model to comment on the merits of this suggestion. Nothing in the experience of judges or the process of the courts suggests they are particularly well qualified to provide a speedy approval process for governmental emergency action. One difficulty is that courts will be obliged to hear individual applications to enforce public health statutes and emergency orders as well as challenges against emergency declarations and emergency orders. The courts' prior involvement in the process of oversight and review of such orders could make it difficult to provide a detached and independent forum for the adjudication of applications to enforce such orders and challenges against such orders.

Turning back to the two principal models under discussion, two major changes since 1981 suggest, to those who advocate the Bill 138 model, that the inherent powers model is no longer sufficient to protect against emergencies.

The first major change was the advent in 1982 of the *Canadian Charter of Rights and Freedoms*. It revolutionized our legal system by a new emphasis on individual rights and increased scrutiny of governmental action by way of judicial review. Although the Charter did not sweep away the existing inherent powers discussed above it became infinitely more important for governments, in defending their actions, to rely on explicit sources of power supported by rational arguments marshalled in advance of the exercise of the power.[352]

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[350] Justice Policy Committee, Public Hearings, August 16, 2004, p. 78. See also the remarks by Mr. Alan Borovoy, general counsel of the Canadian Civil Liberties Association, before the Justice Policy Committee on October 14, 2004, at p. 347.

[351] Toronto Star, Editorial, November 3, 2004.

The second major change is the increasingly serious and complex nature of the threats that might require emergency action, a terrorist attack of an unforeseen nature or an influenza pandemic to take two examples only. The argument that broad and explicit emergency powers are required to combat these new threats was made by Dr. James Young in his letter to the Premier dated June 21, 2004:

> Although we have made significant advancements in the Province's state of emergency preparedness, the risk situation from a number of factors including terrorism, global warming, interconnected and aging infrastructure, and pandemics is greater today than at any point in the province's history. We continue to address these issues at all levels of government and are making steady progress in our ability to respond.

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[352] It was acknowledged during the Justice Policy Committee hearings that there are arguments for and against the sufficiency of inherent powers and the need for explicit emergency powers. The following exchange took place on August 19, 2004 between Mr. Kormos and Mr. Twohig of the Attorney General's Department:

> Mr. Twohig: Certainly, if you go back to the white paper of 1981, we had the Mississauga train derailment, we have Mr McMurtry-and it's right in the paper. They say, "We consider the need for special powers," and we say no. We say…
>
> Mr Kormos: And McMurtry is a pretty smart guy.
>
> Mr Twohig: Well, and he says, "We'll leave it to the common law." That was 1983 or 1981. When you look at the other provincial statutes-and we were discussing it this morning-of the other nine provinces and the federal government, seven of those jurisdictions, post-charter, have passed legislation with these wide, sweeping powers. They thought it was necessary. Presumably they read the McMurtry paper and disagreed. But that question, whether there's a need or not, I can't carry that. I was asked to assume that there was a need, and if we asked you to construct the powers with appropriate checks, what would it look like?
>
> Mr Kormos: Fair enough. But now, because we talked about that just a little bit here in the committee, because we've got that McMurtry white paper, the 1981 paper, and all of us-I think it's pages 26, 27, 28, and boom, right to that special powers, you'll see it. It's not the same politics as mine, but I knew him as a smart guy when he was justice minister and I consider him a pretty smart guy now. Maybe he's changed his mind, but do you dispute the conclusion he reached as a lawyer?
>
> Having said that, because we also tried to reflect on what changed from 1981, the only thing we could think of was the charter, right? So I suppose I'd ask you to tell us what about the charter would change or impact on the conclusions that Minister McMurtry, as he was then, reached in his report of 1981.
>
> Mr Twohig: I absolutely take no issue with the fact that there is an argument. That's the threshold question: Is there a need for change? Did the charter in fact make McMurtry's argument even stronger? I appreciate that that's an argument, but to address that argument, I never got to that. I was asked to assume that there was a need, and if there was a need, the direction was, "Have something ready. We don't want to be caught If it turns out that people aren't following directives, if it turns out that the evacuation of people needs to take place and someone says, 'Well, wait a minute; you don't have the authority to do it,' what would those powers look like?" That's what I did. But your question is certainly the critical threshold question.

> Clearly, one of the best ways to guide our preparation is to learn from our past experiences. With this goal in mind, I would like to specifically comment on some deficiencies in our emergency legislation. The 1998 ice storm and particularly the 2003 SARS and power blackout emergencies, have demonstrated limits in our current legislation.
>
> In the event of a declared provincial emergency, the *Emergency Management Act* concentrates existing legislative power in your hands, but does not add any additional powers to manage the unique issues that arise during an emergency. For example, it is not clear if you could force an evacuation or control the distribution or price of vital supplies such as gas, electricity or medical protective equipment. In concert with other ministries, we have been looking at a range of potential powers and comparing our proposed approach with existing legislation in other provinces. Currently, Ontario has the weakest legislation in the country. The additional powers we have considered appear in other provincial or federal legislation and most of the legislation describes these powers in similar ways. Any additional powers, of course, must be used carefully in an emergency and an accountability mechanism should be built into their use. The overriding principle, however, is that these powers are necessary to protect public safety in an emergency situation.
>
> I believe that our research and analysis has evolved to a point where we can offer constructive and comprehensive advice to you concerning necessary legislative amendments to the *Emergency Management Act*.
>
> For your information, I am attaching to this letter a jurisdictional analysis of emergency powers legislation in other provinces.

Dr. Young's letter was supported by a chart showing that the federal government and every province except Ontario had enacted emergency legislation along the general model represented by Bill 138.

Correspondence between the Commission and the Ministry of Health and Long-Term Care in Appendix H makes it clear that the government is committed to the second model represented by Bill 138. The Commission has no mandate in respect of emergency legislation generally or the particular model the government chooses to use for all emergencies including public health emergencies.

The model chosen raises natural concerns by reason of its extremely open-ended and vague powers to make emergency orders, coupled with the awesome power to override existing laws whenever the government considers it necessary. There are however three arguments in favour of an explicit powers model that may make it difficult to oppose at least in some modified form after a major legal overhaul by the Attorney General.

The first argument is that every other jurisdiction in Canada has adopted some form of explicit emergency power regime of the kind generally represented by Bill 138, putting a burden of persuasion on those who argue that Ontario should choose a radically different model such as an inherent power model.

The second argument is that you can never in this day and age foresee exactly what form an emergency may take and therefore you can never legislate in advance the precise limits of all the powers that may be necessary to protect the public.

The third argument is based on evidence of increasing concern about legal liability and legal authority. Many who stepped up to the plate during SARS, and complied unquestioningly with directives rather than challenging their legal authority, suggest that they might not do so again in the absence of explicit legal authority because of concern about their own legal obligations and potential liability.

Emergency Response: Two Inherent Dangers

Emergency powers are inherently dangerous. They carry the twin dangers of overreaction and underreaction.

The first danger is overreaction. As noted above every emergency power, once conferred, "lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need."[353] To a hammer, everything looks like a nail. To some emergency managers, every problem may look like an opportunity to invoke emergency powers.

The second danger is underreaction. In face of a deadly new disease with an uncertain incubation period, ambiguous symptoms, no diagnostic tests, uncertainty as to its infectiveness and mechanisms of transmission, and no idea where in the province it may be simmering, decisive action may be necessary that turns out in hindsight to have been excessive.

The problems of overreaction are familiar to the legal system. Lawyers and legislators and courts and judges have become adept over the years at preventing the problems of overreaction by means of legislative safeguards. These legislative safeguards will be addressed below in the discussion of Bill 138.

The legal system is not designed to prevent the problems of underreaction. Although a public body might be sued after the fact for failing to prevent a problem such as an attack by a known sexual predator, these lawsuits are complex and they do nothing to prevent the problem in the first place. All the legal system can do is ensure that the emergency managers are not hamstrung by legislative requirements that prevent them from acting unless and until they can prove objectively that emergency action is necessary. Such objective standards may prevent emergency managers from acting until it is too late.

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[353] Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the race-based internment of Japanese Americans during WW II.

The precautionary principle addresses the problem of underreaction by pointing out that in the face of a grave risk it is better to be safe than sorry:

> The absence of full scientific certainty shall not be used as a reason for postponing decisions where there is a risk of serious or irreversible harm.[354]

Mr. Justice Krever emphasized this principle in the Commission of Inquiry on the Blood System in Canada:

> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.[355]

Suggestions that the authorities overreacted during SARS, and suggestions that the authorities underreacted during SARS, are questions for the Commission's final report. It is enough to say now that the precautionary principle may require emergency managers to overreact in order to avert a threat of unknown proportions. Dr. James Young addressed this issue in the hearings of both the SARS Commission and the Justice Policy Committee:

> And so, in my view, the only way of combatting something like this, is to go after it very hard and very fast and attempt to get far enough ahead that, in fact, if we have any breakout it's very limited. Areas that did not do this at the beginning, such as Beijing, ended up with a much bigger outbreak because, in fact, that was the only way of getting in front of it.[356]
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>
> Unfortunately, the safest and the best way when you're thinking about emergencies and potential emergencies is to overreact and then cut back rather than under-react. If you play catch-up and you under-react and you make mistakes, you'll spend much longer trying to repair the damage and the human or economic loss will be much greater.[357]

The only legal solution to the problem of underreaction is to permit the application of the precautionary principle by ensuring first that the emergency managers have all the necessary legal tools and legal powers they require, and second that they are not unduly hampered by objective standards that require too high a level of proof before sensible precautions can be imposed.

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[354] Privy Council of Canada, *A Framework for the Application of Precaution in Science-based Decision Making About Risk* (Ottawa: 2003), p.2

[355] *Commission of Inquiry on the Blood System in Canada*. Final Report at page 295, see also pp. 989-994.

[356] SARS Commission Public Hearings, September 30, 2003, p. 36.

[357] Justice Policy Committee, Public Hearings, August 3, 2004, p. 12.

The central task of emergency legislation is to guard against overreaction by providing safeguards and to guard against underreaction by avoiding legal restrictions that prevent the application of the precautionary principle.

Role of Chief Medical Officer of Health

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health, free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to doctors, not to politicians or government managers. It is essential that the public get from the Chief Medical Officer of Health the facts about infectious risks to the public health and the degree that precautions are needed and advice on how they can avoid infection. It is essential when public precautions are relaxed, like the removal of protective respirators in hospitals, the re-opening of hospitals or the declaration that it is business as usual in the health system, that these decisions are made and are seen to be made by and on the advice of the independent Chief Medical Officer of Health. It is essential in a public health emergency, or the public health aspects of an emergency such as flood-borne disease, that the Chief Medical Officer of Health be the public face of public communication from the government.

Health Minister George Smitherman highlighted the vital role of the Chief Medical Officer of Health when he introduced amendments in October 2004 to the *Health Protection and Promotion Act*[358] enhancing the independence of the Chief Medical Officer of Health. He told the Ontario legislature:

> The position of chief medical officer of health is probably not one that most Ontarians think about very often. After all, you don't generally think about your doctor until you have a health problem. The chief medical officer of health, or CMOH, is, in a very real sense, the top doctor for 12 million Ontarians. So it's only when there is a public health problem that has the potential to affect anyone and everyone that this position suddenly takes on its extremely important public profile.
>
> When there is a health crisis and politicians speak, some people listen. But when there is a health crisis and the chief medical officer of health speaks, everybody listens. It is at those times, times when diseases like SARS or West Nile are a real threat, that the chief medical officer of health must be there for his or her patients, all 12 million of them. It is at times like those that the chief medical officer of health must be able to interact with his or her patients without worrying about what the Minister of Health might think, what the effect might be on the government or what the opposition might say. We learned that lesson as a province during Walkerton, West Nile and

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[358] The amendments were introduced in Bill 124, which was passed by the Ontario legislature on December 15, 2004, and received Royal Assent one day later.

> SARS. We learned that what Ontarians wanted, what they needed, from their chief doctor was his or her undivided attention.[359]

The government, as noted above, has started to strengthen the independence of the Chief Medical Officer of Health and the Commission has recommended the completion of this task together with a parallel measure of independence for the local medical officer of health. These additional measures are necessary to ensure that these trusted medical figures have the actual independence and the perceived independence necessary to secure public confidence that whatever they do and whatever they say in a public health emergency is for the public's health and not for some political or bureaucratic expediency.

The importance of the independence and leadership of the Chief Medical Officer of Heath and medical officers of health during an emergency was emphasized by one professional association:

> The provincial Chief and local Medical Officers of Health should be granted authority in managing the health aspects of any emergency and possess full authority delegated by the Provincial Commissioner of Emergency Management or municipal Chief of Emergency Management in managing a health emergency. This should be addressed in the Emergency Management Act itself.
>
> There is also a clear conflict of interest that may develop during an emergency if the "political will" of the government of the day stands in the way of actions that need to be taken by the Chief Medical Officer of Health to protect the health of the public. This is to say, that there may be clear variance from a government's policy directions in the choices made by the Chief Medical Officer of Health in order to protect the public. The Chief Medical Officer of Health needs to be given the authority to act and protected in the EMA from recourse of such choices.
>
> Further to this, it remains unclear whether the HPPA or the EMA is the more powerful, and hence presiding legislation, during health emergencies. When the emergency is declared it is clear that the EMA is the dominant legislative authority, however as mentioned above, the EMA does not deal with health emergencies, and therefore the linkages between the players in the system. Where the control lies, either with the CMOH or MOH, and the role of each in decision-making and the custodianship of emergency planning, management, and recovery plans needs to be more clearly defined.

The emergency role of the Chief Medical Officer of Health and medical officer of health should, as recommended above, include the fullest direct authority for public health emergency planning. While the medical officers will, of course, consult other agencies in the development of public health emergency plans, there should be no mistake as to who is in charge of the public health emergency planning process. It is for instance unacceptable, for the reasons noted above, that provincial public health emergency planning not be under the authority of the Chief Medical Officer of Health.

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[359] Legislative Assembly of Ontario, October 14, 2004, p. 3388.

To give the Chief Medical Officer of Health special authority in public health emergencies and the public health aspects of more general emergencies is to provoke the excellent question: who's in charge? How can you have the Commissioner of Emergency Management in charge of the emergency and the Chief Medical Officer of Health in charge of its public health aspects? Does that not invite the SARS problem of unclear authority? The rhetorical answer is to ask "in charge of what?" There should be no difficulty, when lines of authority are clear and a good working relationship is ensured in advance by consultation, protocols, and drills, in an incident management system where the Chief Medical Officer of Health is in charge of the medical aspects and the Commissioner of Emergency Management is in charge of everything else. The inevitable boundaries issues can be solved by cooperation, advance planning, and, above all common sense. All that is required is for the Commissioner of Emergency Management and the Chief Medical Officer of Health, whoever may succeed to those jobs from time to time, to park their egos outside the door of the incident room and get on together with the job of managing the emergency. Both require not only confidence in their authority but also a clear acceptance of their mutual roles and limitations.

Key members of the Ontario SARS Scientific Advisory Committee recommend the following:

> At the provincial level, the Commissioner of Emergency Management should have the power and authority to manage all provincial emergencies and be accountable directly to the Premier. Where an emergency principally involves health, this authority should be delegated to the Chief Medical Officer of Health with coordination, support and authority to manage all the non-health aspects of the emergency remaining with the Commissioner of Health Management.
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> If the Chief Medical Officer of Health is the incident commander during a health emergency, it follows therefore that all other health sectors are accountable to the Chief Medical Officer of Health. This was the premise during the SARS outbreak and worked to the extent that proper command and control structures were exercised, and now the Emergency Management Unit of the Ministry of Health and Long-Term Care is the coordinating structure by which provincial health care providers and organizations would report to the Chief Medical Officer of Health during an emergency and this should be recognized in legislation. During the SARS outbreak there was duplication of information and efforts from within the MOHLTC. One central Emergency Management Unit reporting to the Chief Medical Officer of Health will avoid duplication and confusion.

This means that, during a public health emergency, the Chief Medical Officer of Health must be an integral part of every emergency committee, from the highest level down, that is relevant to containing the emergency, even if it is a committee whose meetings normally would only be open to the Commissioner of Emergency Management. Otherwise, the independent accountability of the Chief Medical Officer of Health for public health risk communication and the Chief Medical Officer of Health's exclusive authority over medical decisions are nullified.

Dr. Sheela Basrur described her public health emergency role during testimony to the Justice Policy Committee:

> The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is. For infectious diseases, I think it needs to be the chief MOH. For other emergencies, whether it's a toxic release or a radiation accident or a major flood, there may well be health implications attached to those, but it's not as clear to me that the Ministry of Health and the public health division is the lead agency for the care and control of the incident. They are absolutely going to be main supporters of the response, but not necessarily the lead. That's the distinction I would make.
>
> We can probably have a long debate, till the end of the day, about what's a public health emergency where you might have a mixture. They talk about the spectre of, let's say, a dirty bomb. A dirty bomb might be an explosive device that contains either nuclear or radioactive material, or it may have some real or perceived infectious pathogens in it. You're going to have mixed responsibilities, mixed jurisdictions. You'd have to deal with that on a case-by-case basis, and everyone is going to have to work together extremely closely anyway.[360]

To meet the problem of divided leadership during SARS, Dr. Basrur suggested that the Chief Medical Officer of Health be the one issuing directives in a public health emergency:

> During SARS, as you are aware, there were a multitude of directives issued under the authority of the two commissioners – the Commissioner of Emergency Management and the Commissioner of Public Health – and many comments back that people were unsure who was in charge because there were two signatories; there were always two people who had to be consulted. I would say that if you have a public health emergency, which means primarily that you have an infectious disease emergency for which public health is clearly the lead agency, it is wise, in my opinion, for those directives to be issued under the authority of the chief MOH. That's not to say that the chief MOH wouldn't check in with a whole lot of people: Dr. Stuart – honorary doctor; lucky you – as the director of the emergency

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[360] Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.

> management unit; obviously with the deputy minister; with Dr. Young over where he is, and so on. I'm sorry; the acronym escapes me.[361]

Dr. Donald Low told the Justice Policy Committee:

> Let me just, again, put my focus on a couple of these issues that I thought were particularly important. One was critical: the identification of somebody who is really in charge. During this outbreak, that didn't happen, and I really would support that we identify who that person should be. Obviously, in medical emergencies, it should be the chief medical officer of health, and not only that that person has the authority, but also the authority to appoint individuals to assist with the investigation and managing of the outbreak.[362]

The Commission therefore recommends that emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:

- Public communication of health risk, necessary precautions, regular situation updates;
- Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;
- Strategic advice to the government in the management of the emergency;
- Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;
- Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;
- Delegated authority in respect of emergency orders of a public health nature; and
- Such further and other authority, of a nature consistent with the authority referred to above, in respect of the public health aspects of any emergency.

This primary emergency authority carries with it the duty to consult with the Commissioner of Emergency Management and other necessary agencies. Although this is just basic common sense, it would be well to make the duty of consultation explicit as a public signpost enshrined in legislation. This public signpost would ensure that the problems never happen again that arose during SARS in respect of the office of Chief Medical Officer of Health. The office of the Chief Medical Officer of Health must never, no matter who succeeds to the office from time to time, become a separate silo as it sometimes appeared to others during SARS, jealous of its own authority and reluctant to cooperate and share that authority with other agencies.

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[361] *Ibid*, p. 142.

[362] *Ibid*, p. 146.

The Commission therefore recommends that emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.

The details of the consultation and cooperation between the Commissioner of Emergency Management and the Chief Medical Officer of Health need not be reduced to legislative form. It is not, for instance, necessary to specify in legislation whether emergency directives to hospitals be cosigned by the Chief Medical Officer of Health and the Commissioner of Emergency Management as they were during SARS. This kind of detail should be worked out in advance between them in a protocol or memorandum of agreement that is flexible enough to allow for the unexpected and clear enough to point the holders of both offices, and those with whom they work, along a simple path of cooperation.

Recommendations

The Commission therefore recommends that:

- **Emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:**
  - **Public health emergency planning;**
  - **Public communication of health risk, necessary precautions, regular situation updates;**
  - **Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;**
  - **Strategic advice to the government in the management of the emergency;**
  - **Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;**

  - **Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;**

  - **Delegated authority in respect of emergency orders of a public health nature; and**

  - **Such further and other authority, of a nature consistent with the authority referred to above, in respect of the public health aspects of any emergency.**

- **Emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.**

Specific Public Health Emergency Powers

The first line of public health emergency defence, as noted above, is to stop emergencies before they start by arming the Chief and local medical officers of health through the *Health Protection and Promotion Act* with stronger daily powers to prevent the spread of infection. The measures recommended above will provide a strong shield against the onslaught of public health emergencies.

But public health emergencies will arise despite the greatest vigilance of public health authorities and the most vigorous exercise of their daily powers.

The quintessential public health emergency is an outbreak of infectious disease that overwhelms the capacity of the public health system. The most serious predictable public health emergency is pandemic influenza which would overwhelm not only the public health and hospital and medical systems but also the other systems that keep the province going. Pandemic influenza exemplifies the need for strong emergency powers.

Three times in the last century radical new influenza strains have emerged to cause global pandemics.[363] The worst was in 1918-19 when 20 to 50 million people died worldwide, including an estimated 30,000 to 50,000 people in Canada. Leading experts agree a flu pandemic that could kill millions around the world[364] is inevitable and overdue.[365]

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[363] Pandemic is defined as "An epidemic occurring worldwide, or over a wide area, crossing international boundaries, and usually affecting a large number of people." Source: Last, John M., ed., *A Dictionary of Epidemiology* (Oxford, U.K.: 2001), p. 131.

The Ontario Health Pandemic Influenza Plan, which suggests that a flu pandemic in the province could result in as many as 52 thousand hospitalizations, 2.25 million outpatient visits, and 12 thousand deaths,[366] said:

> Although no one can predict when the next influenza pandemic will hit, public health officials have warned that a global influenza pandemic is overdue.[367]

A study by experts at the Institute of Medicine of the National Academies in the U.S. said:

> All influenza virologists agree that a new pandemic is imminent.[368]

Health Canada said:

> A pandemic can occur at any time, with the potential to cause serious illness, death and colossal social and economic disruption throughout the world.[369]

The WHO has identified three prerequisites for the start of a pandemic:

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[364] "Even in the best case scenarios of the next pandemic, 2 to 7 million people would die and tens of millions would require medical attention. If the next pandemic virus is a very virulent strain, deaths could be dramatically higher." (Source: WHO, "Estimating the impact of the next influenza pandemic," December 8, 2004.) Also note that Peter Sandman and Jody Lanard, American experts in risk communication, have said: "Estimates of how many people a flu pandemic will kill are basically informed guesses. Nobody knows how virulent the influenza strain that launches the pandemic will be, or how that strain will attenuate or intensify once it starts to spread; nobody knows what percentage of the world's population will be infected or what percentage of those infected will die; nobody knows how soon a vaccine will be mass-produced and distributed; nobody knows how well the vaccine will work or how successful "social distance" strategies will be in the meantime." (Source: Lanard, Jody and Sandman, Peter, "Pandemic Influenza Risk Communication: The Teachable Moment.")

[365] Some experts like Sandman and Lanard have questioned whether there is sufficient evidence to believe pandemics are cyclical: "If there are really reasons for thinking flu pandemics are cyclic (for example, if going decades without a pandemic makes the human population more vulnerable to a novel strain) then this makes sense. But we haven't seen it argued as a scientific proposition … If pandemics are random events, then each year's odds are the same, regardless of what happened the year before," See: Lanard, Jody and Sandman, Peter, "Pandemic Influenza Risk Communication: The Teachable Moment."

[366] Ministry of Health and Long-Term Care, *Ontario Health Pandemic Influenza Plan* (Toronto: May 2004) p. 6.

[367] *Ibid*, p. 10.

[368] Institute of Medicine of the National Academies, *Microbial Threats to Health* (Washington: 2003), p. 146.

[369] Health Canada, *Canadian Pandemic Influenza Plan* (Ottawa: February 2004), p. 17.

1. A novel virus subtype must emerge to which the general population will have no or little immunity.

2. The new virus must be able to replicate in humans and cause serious illness.

3. The new virus must be efficiently transmitted from one human to another; efficient human-to-human transmission is expressed as sustained chains of transmission causing community-wide outbreaks.[370]

The WHO believes that the H5N1 virus, which has caused unprecedented outbreaks of highly pathogenic avian influenza in large parts of Asia, has met the first two prerequisites:

> All prerequisites for the start of a pandemic had been met save one, namely the onset of efficient human-to-human transmission. Should the virus improve its transmissibility, everyone in the world would be vulnerable to infection by a pathogen – passed along by a cough or a sneeze – entirely foreign to the human immune system.[371]

Concludes the WHO:

> During 2004, the world moved closer to a further pandemic than it has been at any time since 1968.[372]

Dr. Julie Gerberding, director of the CDC, believes H5N1 represents the "most important threat we are facing right now."[373]

Raising the level of concern over H5N1 are reports that create doubts about the reliability of laboratory tests in some affected areas of Asia, raising the possibility that the virus's progress may have been underestimated.[374]

Some experts, however, question whether the next pandemic will be triggered by the H5N1 virus. They question whether there is sufficient scientific evidence to point definitely to H5N1 as the cause of the next pandemic. Some skeptics even go so far as to suggest that the fear factor is good business for agencies and industries with a vested interest in directing public attention and public funds to emergency preparedness.[375]

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[370] WHO, "Avian influenza: Assessing the pandemic threat," (Geneva: January 2005), p.11.

[371] *Ibid,* p.11.

[372] *Ibid,* p.3.

[373] Macleans, "Bracing for bird flu," March 16, 2005.

[374] Los Angeles Times, "Many scientists fear bird flu cases exceed data," March 16, 2005.

It would of course be unwise to accept at face value, without critical analysis, every portent of disaster. History has not been kind to Cassandra or Chicken Little. Those who warn of disasters have been accused throughout history of simply trying to scare people. Whether the next pandemic will be caused by H5N1 or another novel disease, or whether fears about H5N1 may, in hindsight, turn out to be exaggerated, it would be reckless not to prepare for the next pandemic. As the U.K. Ministry of Defence's Chief Scientist has said:

> Although it sounds alarmist, the balanced view is that we are overdue a major pandemic.[376]

Prudence and precaution require that effective planning and preparedness for an influenza pandemic be undertaken.

Although Ontario got through SARS without any special emergency powers, the prospect of pandemic influenza brings home the need for such powers. Even if all the emergency measures taken during SARS were explicitly enshrined in emergency legislation, those measures would be hopelessly inadequate in the face of a much larger infectious attack such as pandemic influenza.

SARS infected hundreds of people and killed 44 in Ontario. While one death from infectious disease is one death too many, the overall burden of disease from SARS was much less than the 1918 Spanish flu pandemic and the prospect of future emergencies like an influenza pandemic.

The prospect of pandemic influenza or indeed any outbreak more serious even than SARS requires the enactment of emergency powers stronger than those available during SARS and available now.

It is impossible, as noted above, to draw a bright line between public health emergencies and other emergencies. It is therefore almost a misnomer to refer to "public health emergency powers" as if they were distinct from other powers required when an emergency like pandemic influenza overwhelms the public health system and the ordinary machinery of public safety. It is however convenient as a practical matter to refer to public health emergency powers when discussing those emergency powers that are particularly relevant to the public health aspects of any emergency.

The Commission asked the Ministry of Health and Long-Term Care for its position on powers required in the event of a public health emergency and the then Deputy Ministry of

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[375] CBC News Online, "H5N1: A string of numbers and letters that has the World Health Organization deeply concerned," March 8, 2005; Macleans, "Bracing for bird flu," March 16, 2005.

[376] The Guardian, "Bird flu could put Britain in quarantine, warns scientist," March 27, 2005.

Health Mr. Phil Hassen, in a reply dated August 4, 2004, reproduced in Appendix H, made the following recommendations:

> … [W]ithin the framework of broader emergency response powers, we have been considering enhancements that may be required in our legislation to address specific program issues as they arise in (or prior to or after) any emergency. For example, we will be considering various ways of clarifying the authority to issue directives prior to, during, or after an emergency. This could be achieved by including a general provision in the *Ministry of Health and Long-Term Act*, or provisions in program specific legislation (i.e., legislation governing public hospitals, laboratories, long-term care facilities, etc.).
>
> There is also the possibility of enhancing the ability of the Chief Medical Officer of Health to take action or provide directions as required in any circumstance relating to a public health emergency. A further complementary amendment is to provide a mechanism to expedite the registration of health care professionals in an emergency, and possibly before or after an emergency, to ensure that professionals registered in other jurisdictions could come to Ontario and practice on short notice. This would require amendments under the *Regulated Health Professions Act* and related legislation.
>
> In addition to these potential changes, specific amendments to the *Health Protection and Promotion Act* are discussed in more detail below.
>
> Health Protection and Promotion Act
>
> The current *Health Protection and Promotion Act* ("HPPA") provides extensive powers to address public health issues throughout Ontario. As you know, over the coming year we would initiate changes that will enhance the role of the Chief Medical Officer of Health ("CMOH"), increasing the independence of that office through mandatory reports to the public and increasing the transparency of the appointment process. We hope to proceed with those amendments this fall.
>
> In addition to those changes, we have identified a range of amendments that would work within the framework of broad emergency powers under the *EMA*. The key to the exercise of these powers would be the necessity of a declaration of an emergency under the *EMA* and any exercise of the powers would be subject to the constitutional safeguards under the *EMA*. The main goal of these amendments is to ensure that public health officials have the necessary, extraordinary powers under the *Health Protection and Promotion Act* to address a public health emergency if and when one is declared under the *EMA*. With those parameters in mind, we believe that the following amendments should be considered:

- Authorizing the CMOH to take such action as he or she considers appropriate to decrease the risk presented by the public health emergency.
- Adding new Order provisions to provide for:
    - Mass immunization of individuals or populations, or requiring the isolation of persons where medical contraindications warrant exception from the required immunization;
    - Decontamination in emergency situations, where such action is considered appropriate (decontamination orders are not currently found under the Act, but such procedures may be required for individuals or large groups in the event of a nuclear disaster); and
    - Such other 'orders as may be necessary in an emergency.
- Authorizing medical officers of health to enter any premises, including a private residence, without a warrant, where the medical officer has reasonable and probable grounds to believe there is a risk to health due to a health hazard or an infectious disease.
- Authorizing the Chief Medical Officer of Health to order collection, analysis, and retention of any laboratory specimen from any person, animal, plant, or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analyses from anyone, and to disclose the results of test analyses as the Chief Medical Officer of Health considers appropriate.
- Authorizing the Chief Medical Officer of Health to require any person, organization, government agency or other entity to report information to the Chief Medical Officer of Health as she or he considers necessary, to reduce prevent or eliminate the risk of the emergency.
- Requiring physicians and other regulated health professionals, hospital administrators and operators of other health care institutions to report such information as the medical officer of health considers necessary in the circumstances (at present, physicians and other regulated health professionals are required to report "such additional information" about a reportable or communicable disease case as the medical officer of health considers necessary, under section 1(2) of Regulation 569 – Reports).

  - ○ Adding the Chief Medical Officer of Health to those currently protected from exposure to liability under the Act, such as medical officers of health and members of boards of health. (But note that this proposal would not be restricted to emergency situations.)

The Commission has taken the following approach to the powers sought in the Deputy Minister's letter, and referred to in Dr. Basrur's presentation to the Justice Policy Committee on August 18, 2004:

- As for directives, the Commission has recommended that the *Health Protection and Promotion Act* be amended to provide clear day to day authority to issue directives to health care facilities. Because of the government decision to pour provincial emergency powers into the general vehicle of Bill 138, the Commission recommends that Bill 138's provisions be scrutinized to ensure that it includes the power to issue emergency directives of the kind here requested, particularly if the directive overrides some provision in program specific legislation of the kind noted (i.e., legislation governing public hospitals, laboratories, long-term care facilities, etc.).

- As for the "basket clause," the Commission cannot in light of the powers now in the *Health Protection and Promotion Act* (see, for instance, s. 86) and those recommended in this report, recommend without further evidence a "basket clause" in the *Health Protection and Promotion Act* authorizing the Chief Medical Officer of Health to take such action as he or she considers appropriate to decrease the risk presented by the public health emergency. In the first place, the powers in s. 86 are already very wide. In the second place, the power requested is not restricted to matters similar to those already within the jurisdiction of the Chief Medical Officer of Health and is therefore a power without limits. In the third place, the government's decision to proceed with Bill 138 suggests that any emergency "basket power" belongs in s. 7.0.2(3)12 of Bill 138.

- The power of registration and licensure is apparently addressed in s. 7.0.2(3)10 of Bill 138 which should be scrutinized to determine whether it provides the authority contemplated by the Ministry of Health and Long-Term care. The licensure and registration for health professionals qualified to practice outside Ontario was identified to the Commission by a number of professional groups and health care institutions.

- As for compulsory mass immunization, the Commission suggests below that further analysis and evidence is required before this power is ripe for enactment as a permanent feature of our laws.

- Decontamination is addressed in the Commission's recommendations above. The position of the Commission is that the powers associated with decontamination should be available without a declaration of emergency. If hundreds of people are covered with white powder that appears to be weaponized anthrax, immediate action is required without waiting for a provincial declaration of emergency.

- Powers of entry to a private dwelling without warrant are addressed in the Commission's recommendations above as daily powers in the *Health Protection and Promotion Act* with the safeguards associated with the Supreme Court of Canada judgment in *Feeney*. If additional powers of entry are required in an emergency they should be addressed in Bill 138, which presently contains no such powers.

- The collection of laboratory samples is addressed in the Commission's recommendations for daily *Health Protection and Promotion Act* powers. These powers apply only to samples already collected because any power to take bodily samples from a person without consent and without court order engages serious issues under the *Charter of Rights*. No such power is proposed in Bill 138.

- The disclosure of personal health information to the Chief Medical Officer of Health and medical officers of health is addressed in the Commission's recommendations for increased daily powers in the *Health Protection and Promotion Act*. Emergency disclosure of personal health information is addressed in s. 7.0.2 (4) 11 of Bill 138 and also in s. 7.0.2 (9) and s. 7.0.2 (10) of Bill 138.

- Liability protection for the Chief Medical Officer of Health is addressed in the Commission's recommendations under the *Health Protection and Promotion Act*.

This completes the list of public health emergency powers suggested by the Ministry of Health in the Deputy Minister's letter of August 4, 2004, and referred to by Dr. Basrur in her appearance before the Justice Policy Committee on August 18, 2004.

Because the government has chosen the Bill 138 general power approach, it would be helpful to test the Bill 138 powers to ensure that they cover not only the matters addressed above but also the matters addressed specifically in the emergency public health legislation from other jurisdictions. The following list, which is non-exhaustive and overlaps some of the issues discussed above, is drawn from the Model State Emergency Health Powers Act in the U.S., the statutes of American jurisdictions and other Canadian provinces and from suggestions by those involved in the public health response to SARS:

EXAMPLES OF TEMPORARY COMPULSORY POWERS

- Powers of the kind presently authorized under the *Health Protection and Promotion Act* for daily use, that are wider than those authorized for daily use.

- Compulsory procurement of facilities, supplies and materials.
- Power to ration medical supplies.
- Power to issue directives throughout the health care system that override existing legal provisions, e.g., patient transfer.
- Power to require services from facilities, institutions, and individuals.
- Power to take over and manage facilities.
- Power to destroy livestock.
- Power to evacuate buildings and neighbourhoods.
- Power for the safe disposal of human remains including any necessary override of related statutes such as the *Coroner's Act.*
- Power for the safe disposal of infectious waste.
- Power to detain or to enter premises including dwelling places beyond that authorized by *Health Protection and Promotion Act.*
- Power to obtain personal health information beyond that authorized by the *Health Protection and Protection Act.*
- Power to override licensure requirements for health professionals and others.
- Power to support volunteers through compensation and insurance.
- Power to support those quarantined and isolated through compensation and other forms of assistance.
- Power to expand existing compensation schemes (e.g. OHIP,) to provide for emergency services.
- Power to protect, from personal liability, individuals who act reasonably and in good faith, without denying existing rights of legal recourse against institutional employers.[377]

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[377] For a good example of effective liability protection see *Health Protection and Promotion Act* s. 95 which now provides:

> 95. (1) No action or other proceeding for damages or otherwise shall be instituted against a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector for any act done in good

Recommendation

The Commission therefore recommends that:

- **Bill 138 be subjected to a fundamental legal and constitutional overhaul by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.**
- **The government in its review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to above.**

Compulsory Mass Immunization: A Paradigm

The power of compulsory mass immunization is a paradigm for public health emergency powers. Compulsory mass immunization exemplifies the legal, policy and practical problems

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> faith in the execution or the intended execution of any duty or power under this Act or for any alleged neglect or default in the execution in good faith of any such duty or power. R.S.O. 1990, c. H.7, s. 95 (1).
>
> Exception
>
> (2) Subsection (1) does not apply to prevent an application for judicial review or a proceeding that is specifically provided for in this Act. R.S.O. 1990, c. H.7, s. 95 (2).
>
> Board of health not relieved of liability
>
> (3) Subsection (1) does not relieve a board of health from liability for damage caused by negligence of or action without authority by a person referred to in subsection (1), and a board of health is liable for such damage in the same manner as if subsection (1) had not been enacted. R.S.O. 1990, c. H.7, s. 95 (3).

Compare and contrast this provision with the liability protection in the Attorney General's Draft Bill which provides:

> 11. (1) No action or other proceeding lies or shall be instituted against a person designated in subsection (3) for doing any act or neglecting to do any act under this Act or under any order under this Act.
>
> (2) Despite subsection (1), a person described in subsection (3) is liable where a claim of gross negligence is proven in the carrying out of an act or in neglecting to carry out an act under this Act.

and the contrasting provision in Bill 138 which provides:

> 11. (1) No person designated under subsection (3) is liable for any act done in good faith in the exercise or performance or the intended exercise or performance of any power or duty under this Act or under an order made under this Act or for any neglect or default in the exercise or performance in good faith of such power or duty.
>
> (2) Despite subsection (1), a person described in subsection (3) is liable for an act done in the exercise or performance or the intended exercise or performance of any power or duty under this Act or under an order made under this Act or for any neglect or default in the exercise or performance of such power or duty where a claim of bad faith or gross negligence is proven.

that must be addressed in every analysis of every proposed public health emergency power and any proposed general emergency power. The issue is addressed at greater length than other proposed public health emergency powers for two reasons. First, because it has attracted less policy analysis and discussion than other proposed powers such as the power to ration medical supplies. Second, because it bristles with legal issues that typify any emergency proposal to interfere with individual liberties for the sake of the greater public good. The purpose of this section is not only to demonstrate that the power of mass compulsory immunization is not yet ripe for enactment, but also to demonstrate the type of legal, practical, and policy analysis that should be taken in respect of every proposed emergency power before it is enacted.

Mass immunization by order is a hot-button issue. It engages serious issues that require careful consideration.

Ontario officials seek the power to order mass immunization in a widespread public health emergency such as an influenza pandemic[378] and to isolate those who cannot or will not be immunized.[379] Mass immunization by order, particularly if refusal invites isolation or suspension from health care work or jail, is very different from voluntary immunization.

The question to be confronted is whether the evidence to support the power to order mass immunization, and the accompanying power to isolate or refuse work to those who decline, has been presented in any comprehensive fashion. It may be that a case for mass immunization by order can be made that adequately addresses the fundamental issues noted below. Until the evidence in support of such a case has been presented in a comprehensive fashion, it is difficult to say that this power, as opposed to a purely voluntary immunization programme with effective public education, is ripe for enactment at this time as a permanent feature of Ontario's law.

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[378] Other potentials for mass immunization by order include bioterrorism attacks involving anthrax or weaponized smallpox.

[379] Deputy Minister of Health Phil Hassen in his letter to the Commission of August 4, 2004 recommended the enactment, within the context of a broad emergency statute, of power to order:

> Mass immunization of individuals or populations, or requiring the isolation of persons where medical contraindications warrant exception from the required immunization.

Chief Medical Officer of Health Sheela Basrur made the same point in her evidence before the Justice Policy Committee on August 18, 2004:

> Additional authorities that probably will be necessary before we have such things as pandemic influenza would be an ability of the chief medical officer of health to make orders regarding mass immunization of individuals or populations. Right now, from SARS we had the experience that we needed to issue an order against classes of people, but there was no vaccine. What if there had been a vaccine? I would have had to order, maybe, vaccination one at a time. I'm not sure I have the authority to order vaccination even one at a time, much less against a class of people. If we think about a vaccine-preventable disease emergency, we need to have those provisions in place so we can take action pretty quickly to protect the healthy people from becoming sick.

A prominent feature of the *Model State Emergency Health Powers Act*[380], the power of mass immunization by order is strikingly absent[381] from Ontario proposals in Bill 138 and the staff

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[380] This American model statute has provoked some controversy because of its coercive powers. Initially released on October 2001, it was amended in December of that year.

An article in the New England Journal of Medicine stated:

> On December 21, 2001, in response to criticisms of the model act … a revised version was released. No one any longer considers the act a "model." Instead, it is now labeled a "draft for discussion." The new version does "not represent the official policy, endorsement, or views" of anyone, including the authors themselves and the CDC. (Source: Annas, George J., Bioterrorism, Public Health and Civil Liberties. New England Journal of Medicine, Volume 346:1337-1342, April 25, 2002).

An article in Medical Student JAMA stated:

> The MSEHPA has been criticized for vesting enormous powers in the nation's governors; for allowing governmental authorities to seize and control private property during a public health emergency and not be held liable in case of their damage or destruction; for allowing the arrest, imprisonment, and forcible examination, vaccination, or medication of individuals without their consent and not be held liable in case of any injury or death; and for being vague in what defines a public health emergency. (Source: Joseph, George D, Uses of *Jacobson v Massachusetts* in the Age of Bioterrorism, Medical Student JAMA, November 5, 2003).

The principal drafters of the *Model State Emergency Health Powers Act* concede that coercive measures like compulsory immunization are controversial, but may nevertheless be needed. In a commentary on the Act, they stated:

> *Managing Property and Protecting Persons.* Authorization for the use of coercive powers is the most controversial aspect of public health laws. Nevertheless, their use may be necessary to manage property or protect persons in a public health emergency … There may also be a need to exercise powers over individuals to avert significant threats to the public's health. Vaccination, testing, physical examination, treatment, isolation, and quarantine each may help contain the spread of infectious diseases. Although most people will comply with these programs during emergencies for the same reason they comply during non-emergencies (i.e., because it is in their own interests or desirable for the common welfare), compulsory powers may be needed for those who will not comply and whose conduct poses risks to others or the public health. These people may be required to yield some of their autonomy or liberty to protect the health and security of the community. (Source: Gostin, Lawrence O., James G. Hodge, Jr. *The Model State Emergency Health Powers Act – Brief Commentary*, Seattle, WA: Turning Point National Program Office at the University of Washington, September 2002, pp. 11-2.)

The Model Act provides as follows: Section 603 Vaccination and Treatment. During a state of public health emergency the public health authority may exercise the following emergency powers over persons as necessary to address the public health emergency-

> (a) Vaccination To vaccinate persons as protection against infectious disease and to prevent the spread of contagious or possibly contagious disease.
>
> > (1) Vaccination may be performed by any qualified person authorized to do so by the public health authority.
> >
> > (2) A vaccine to be administered must not be such as is reasonably likely to lead to serious harm to the affected individual

discussion draft presented to the Justice Policy Committee on August 19, 2004 by counsel for the Attorney General's Department.[382]

Although vaccination statutes do not typically use words like "forced" or "compulsory", immunization is not voluntary if refusal invites forced isolation, loss of employment or jail or suspension from school.[383] Some immunization statutes provide forced vaccination by court order.[384] Any kind of forced medical treatment attracts serious legal issues[385] even in the

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> (3) To prevent the spread of contagious or possibly contagious disease, the public health authority may isolate or quarantine, pursuant to section 604, persons who are unable or unwilling for reasons of health, religion, or conscience to undergo vaccination pursuant to this section.

[381] Although enthusiasts might argue that mass immunization and every other conceivable emergency power is covered by the basket clauses that authorize "such other actions that may be necessary," such arguments stretch the legal imagination.

[382] As Mr. John Twohig told the Committee: "The central piece of material I want to give to you is a piece of draft legislation that we worked on, the so-called contingent legislation should an emergency occur—fortunately it did not occur—during the winter of 2004 …" See Justice Policy Committee, Public Hearings, August 19, 2004, p. 74.

[383] See the *Model State Emergency Health Powers Act*, above, the Ontario ambulance paramedic regulations in the *Katsopoulos* case, below, and Ontario's *Immunization of School Pupils Act* R.S.O. 1990, c. I-1.

[384] Under s. 38(1)(c) of Alberta's *Public Health Act*, R.S.A. 2000, c. P-37:

> 38(1) Where the Lieutenant Governor in Council is satisfied that a communicable disease referred to in section 20(1) has become or may become epidemic or that a public health emergency exists, the Lieutenant Governor in Council may do any or all of the following:
>
> > a) order the closure of any public place;
> >
> > b) subject to the Legislative Assembly Act and the Senatorial Selection Act, order the postponement of any intended election for a period not exceeding 3 months;
> >
> > c) in the case of a communicable disease order the immunization or re-immunization of persons who are not then immunized against the disease or who do not have sufficient other evidence of immunity to the disease.

Amongst the orders available under Quebec's *Public Health Act*, R.S.Q., c. S-2.2, s.123 provides as follows:

> Notwithstanding any provision to the contrary, while the public health emergency is in effect, the Government or the Minister, if he or she has been so empowered, may, without delay and without further formality, to protect the health of the population,
>
> > 1) order compulsory vaccination of the entire population or any part of it against smallpox or any other contagious disease seriously threatening the health of the population and, if necessary, prepare a list of persons or groups who require priority vaccination; …

Section 126 provides as follows:

> If a person fails to submit to a vaccination ordered under section 123, a judge of the Court of Québec or of the municipal courts of the cities of Montréal, Laval or Québec having jurisdiction in the locality where the person is to be found may order the person to submit to the vaccination.

absence of extreme measures like those used in Boston during the smallpox epidemic at the turn of the last century. A disproportionate degree of vaccination was forced on immigrants, blacks, and homeless people.[386]

> Every imaginable threat from civil suits to cold-blooded murder when they got an opportunity to commit it, was made by the writhing, cursing, struggling tramps who were operated upon, and a lot of them had to be held down in their cots, one big policeman sitting on their legs and another on their heads, while the third held their arms, bared for the doctor.

Scientific evidence in favour of immunization is powerful[387] and most pandemic influenza plans provide for its use as a primary means of containing an outbreak.[388]

A strong body of scientific evidence establishes that immunization carries very little risk.

> In addition, the judge may, if satisfied on reasonable grounds that the person will not submit to the vaccination and if of the opinion that the protection of public health warrants it, order that the person be taken to a specific place to be vaccinated.

[385] See the references below to cases in Ontario, Manitoba, and Alberta.

[386] This graphic picture of forced vaccination is provided in Albert MR, Ostheimer KG, Bremen JG *The last smallpox epidemic in Boston and the vaccination controversy*, 1901-1902 N Engl J Med 2001: 344: 375-9, quoted in James J. Misrahi, Gene W. Matthew, and Richard E. Hoffman *Legal Authorities for Interventions During Public Health Emergencies* The Law and Core Public Health Functions Chief Medical Officer of Health. 10, p. 195.

[387] See, for instance, Elizabeth Rea and Ross Upshur, *Semmelweiss Revisited; the ethics of infection prevention among health care workers* CMAJ May 15 2001; Richard E. Schabas, *Mass Influenza Vaccination in Ontario: A Sensible Move* CMAJ 2001:161 (1):36-37; Dr. Schabas adds a note of caution when he says, after noting the arguments in favour of mass immunization, "There are admittedly many uncertainties in this argument. There is because, of course, universal immunization has never before been seriously attempted on this scale."

[388] The Ontario Health Pandemic Influenza Plan states:

> Vaccination is the primary means to prevent disease and death from influenza during an epidemic or pandemic. (Source: Ontario Health Pandemic Influenza Plan, May 2004, p. 37.)

The Canadian Pandemic Influenza Plan states:

> In a pandemic, the current aim is to vaccinate the whole Canadian population over a period of four months on a continuous prioritized basis after receipt of the pandemic seed strain. This would require a minimum of 32 million monovalent doses (8 million doses per month) …
>
> For vaccine program planning purposes it is important to be prepared to immunize 100% of the population; however the actual proportion of the population that will voluntarily seek vaccination will depend on public perception of risk and severity of the disease. Therefore the demand, manifest as clinic attendance, will likely vary between jurisdictions and within each jurisdiction as the pandemic evolves. Previous experience with outbreak related immunization clinics indicates that it would be prudent to prepare for an initial demand of 75% of the target population. It is recommended that planning activities also focus on delivering a two-dose program to ensure that the public health response is ready to deal with this possibility. (Source: Canadian Pandemic Influenza Plan, February 2004, p. 33.)

> Vaccines are among the safest tools of modern medicine. Serious side effects are rare. For example, severe allergic reactions can occur, but they very rarely do. In Canada, this kind of reaction has occurred less than once in every one million doses of vaccine, and there are effective treatments for this condition. The dangers of vaccine-preventable diseases are many times greater than the risk of serious adverse reaction to the vaccine.[389]

Notwithstanding the long history of scientific evidence that vaccination is safe, there is an equally long history of opposition. *The English Vaccination Act* of 1853 provoked violent riots.[390] Closer to home, Montrealers rioted all night against vaccination during the 1885 smallpox epidemic. Even today there is an element of skepticism.[391] Some people doubt that every new vaccine is necessarily safe. They decline vaccination on grounds of conscience, medical risk[392] or simply because they object. These objections raise serious legal[393] and moral considerations.

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[389] Health Canada, *Canadian Immunization Guide, 6th Edition*, (Ottawa: 2002), p. 46.

As for Guillain-Barré syndrome, the *Canadian Immunization Guide, 6th Edition* – 2002, p. 125, stated:

> Guillain-Barré syndrome (GBS) associated with influenza immunization has been observed in a minority of influenza seasons over the last two decades. Apart from the 1976-1977 swine flu season, the risk of GBS associated with influenza immunization is small. In a retrospective study of the 1992-93 and 1993-94 seasons in four U.S. states, the relative risk of GBS occurring within 6 weeks after influenza immunization, adjusted for age and sex, was 1.7 (95% confidence interval 1.0-2.8, $p = 0.04$), suggesting slightly more than one additional case of GBS per million people vaccinated against influenza. In comparison, the morbidity and mortality associated with influenza are much greater.

Dr. Richard Schabas stated:

> Despite these problems, the influenza vaccine works, and works well. In healthy adults its efficacy is between 70% and 90%. Serious side effects are very rare. Guillain-Barré syndrome, for example, is only a complication of the vaccine in a minority of influenza seasons, and even it occurs at a rate of about one in a million doses. (Schabas R.E., *Mass influenza vaccination in Ontario: A sensible move.* CMAJ. 2001 Jan 9; 164(1):36-7.)

Richard E. Schabas, *Mass Influenza Vaccination in Ontario: A Sensible Move*,CMAJ 2001:161 (1):36-37, citing *Canadian Immunization Guide* 5th ed. Ottawa: Health Canada; 1998 p. 103-10 and Lasky T, Terracciano D. O., Magder L, Koski C. L. Ballesteros M.S., Nash D, et al *The Guillan Barre Syndrome and the 1992-1993 and 1993-1994 Influenza vaccines* N Engl J Med 1998: 339: 1797-802.

[390] See Robert M Wolfe & Lisa K Sharp, *Anti-vaccionists past and present*, BMJ 2002; 325: 430.

[391] For contemporary scepticism about mass immunization see the National Post op ed piece of November 22, 2004 by David Dehaas, Editor of M.D. Canada Magazine.

[392] The existence of medical risk is recognized by s. 38 of Ontario's *Health Protection and Promotion Act* which requires adverse vaccination reactions to be reported. The risk is evidenced in court cases where governments have been sued for rare yet devastating medical catastrophes following childhood vaccination. See *Jacques Lapierre v. Attorney General for Quebec* [1985] 1 S.C.R. 241. In the late 1980's a catastrophic vaccination reaction was alleged and supported by significant scientific evidence but the causal connection between vaccination and injury was not ultimately proven in *Rothwell v. Raes* (1988), 66 O.R. (2d) 449 (H.C.J.), affd. (1990) 2 O.R. (3d) 332 (C.A.), application for leave to appeal dismissed (1991), 49 O.A.C. 398 n (S.C.C.), a case of post-pertussis

Ontario law[394] required Bill Kotospoulos, a North Bay ambulance paramedic, to submit himself to influenza vaccination on pain of suspension without pay if he refused. The rationale for the compulsory law was:

> … widespread concerns that health care workers, during the course of their work, have the potential for acquiring and transmitting influenza to those under their care.[395]

Mr. Kotsopoulos objected to compulsory vaccination because:

> I have the ultimate right to give or withhold consent to an injection which invades my bodily and psychological integrity.

Section 7 of the *Canadian Charter of Rights and Freedoms* provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Because Mr. Kotsopoulos refused to be vaccinated the hospital suspended him without pay and he sought a temporary court order to restore his job.

Mr. Justice Norman M. Karam on the basis of the evidence before him assumed that the compulsory immunization regulation was for the public good and that it would damage the public interest to interfere with it.

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vaccine encephalopathy involving severe brain damage and tragic retardation. Osler J. noted (at 515) that some jurisdictions have statutory compensation schemes for persons suffering neurological damage in close temporal association with vaccine administration and agreed with the comments of Krever J. in *Ferguson v. Hamilton Civic Hospitals* (1983), 40 O.R. (2d) 577 at 618-19: "I confess to a feeling of discomfort over a state of affairs, in an enlightened and compassionate society, in which a patient, who undergoes a necessary procedure and who cannot afford to bear the entire loss, through no fault of his and reposing full confidence in our system of medical care, suffers catastrophic disability but is not entitled to be compensated because of the absence of fault on the part of those involved in his care. While it may be that there is no remedy for this unfortunate and brave plaintiff and that this shortcoming should not be corrected judicially, there is, in my view, an urgent need for correction."

It is on the basis of tragic cases like this that any immunization plan should provide a no-fault compensation system for vaccine-injured patients.

[393] For an excellent review of these issues see *Legal Issues and Controversies – Exemptions To Mandatory Vaccinations* http://www.cdc.gov/nip/policies/vacc_mandates_chptr13.htm.

[394] *Ambulance Act, R.S.O. 1990, c. A.19* and its Regulations, *Ambulance Act, Regulation 257/00*, and the Ministry of Health's *Ambulance Service Communicable Disease Standards.*

[395] Rationale For Influenza Surveillance Protocol, quoted in *Kotsopoulos v. North Bay General Hospital,* [2002] O.J. no. 715 (S.C.J.) at para 24.

> ¶ 20 There was extensive evidence provided with respect to the public benefit flowing from influenza vaccination. Influenza is a viral infection that causes serious illness and can be fatal. Statistics provided by the respondents are that it leads to the hospitalization of approximately 75,000 people and results in the deaths of 6,500 in Canada annually. It is particularly dangerous to the elderly, often resulting in complications such as pneumonia and exacerbating heart and respiratory disease. The strength and strain of the virus varies from year to year, and as a result the genetic makeup of each year's vaccine is different, in order to deal with the particular virus prevalent that year. Further evidence was provided that the immunization of health care workers is a necessary step in controlling the spread of the virus, and therefore the death and illness of patients exposed to them.
>
> ¶ 21 I am satisfied on the basis of the evidence provided to me, that influenza is an extremely infectious disease, often leading to hospitalization and death. It is particularly dangerous to the elderly. There is no question that paramedics in the course of their duties are often confronted with health situations involving the elderly. This regulation is clearly designed for no other purpose than to control the disease by taking steps to control its spread. Influenza vaccine is the primary defence in preventing its spread. Immunizing health care workers is one step in that direction. As earlier indicated, this Court, for the purpose of interlocutory proceedings, must therefore assume that the legislation is for the public good, and that any interference would damage the public interest.

The court on the other hand held that Mr. Kotsopoulos raised an important issue, whether his *Charter* rights were violated by the requirement that he submit to immunization on pain of job loss. He argued that immunization would create a risk to his health and a violation of his rights unjustified by any greater public good:

> ¶ 22 The applicant, who has never taken a flu shot, did adduce evidence that there is a risk to his health by immunization for influenza. Opinions were provided that there is a possibility of contracting various diseases through the flu vaccine. While the respondents disputed these allegations and offered evidence that such exposure creates very slight risk, there was an acknowledgement that some risk, however minuscule, does exist. The real issue is whether the applicant should be required, against his wishes, to expose himself to immunization, in the interests of what the Province sees as the necessity to protect the public. Whether the legislation can be justified on the basis that it intrudes upon the rights of an individual not to have substances introduced into his body against his will is a very important issue, but not one that can properly be dealt with on an interlocutory application, in the absence of a complete constitutional review of all of the evidence available.

Mr. Kotsopoulos's main argument was that reinstatement to his paramedic job would create no health risk to others:

> ¶ 23 The main argument raised by the applicant, for the purposes of this application, is that his temporary reinstatement is unlikely to increase the risk of influenza. Although there are province-wide protocols for hospitals and long-term facilities that recommend inoculations against influenza for all caregivers, only paramedics are required to be immunized. No other medical, emergency or critical care personnel are required by statute to obtain a flu shot. The evidence of the applicant is that up to one-third of all of the health care workers in the region have not been immunized against influenza. In addition, in that respect, is the exemption permitted for those paramedics providing a medical certificate establishing that they are medically contra-indicated. In this instance, there are three other paramedics exempted for that reason, at least two of whom are presently on the job, and another who is not working for an unrelated reason. The applicant argues therefore, that in light of these circumstances, his temporary reinstatement would not significantly increase the risk involved. In fact, Dr. Erika Abraham, whose affidavit has been filed on behalf of the respondents, acknowledged as much, when cross-examined for the purposes of this motion. She stated that permitting those paramedics who are contra-indicated to work, without being immunized, constituted an acceptable and minimal risk. Clearly, it follows that there is little difference should there be four instead of three or three instead of two.

The judge reviewed the Ministry of Health policy for gradual universal influenza immunization coupled with education of health care workers. Because the desired level of health care worker immunization had not been reached, the Ministry was exploring various policy and legislative solutions.

> ¶ 24 However, the evidence also indicates that the approach taken by the Ministry of Health has been to proceed gradually with a public program of universal influenza immunization, while at the same time recognizing the importance of the immunization of health care workers. The Rationale For Influenza Surveillance Protocol provides: "This protocol was developed in response to widespread concerns that health care workers, during the course of their work, have the potential for acquiring and transmitting influenza to those under their care." In a published report summarizing the 1998/99 flu season, Dr. Abraham stated:
>
>> "The main strategy of promoting the use of influenza vaccine among health care workers is health promotion and education. Despite the successes of these methods in some settings, the desired level of immunization has not been achieved in health care staff in institutions. In order to reach the targeted level of coverage of above 70%, several working groups of the Ministry of Health, medical officers of health and various professional associations are exploring policy and legislative solutions."

> For that purpose, it would appear that health care workers with the greatest high-risk exposure to patients have been targeted. I can only assume, on the evidence before me, that the requirement for immunization against influenza does not yet extend to all caregivers, such as nurses for example, or even to all paramedics, because at this stage, that is the Province's over-all strategy. Presumably this is due to the fact, as Dr. Abraham indicated in her cross-examination, that paramedics create the greatest risk to the spread of the disease, because their duties are not confined to a single health facility, but exposes them to many or all of them.

Mr. Justice Karam refused Mr. Kosopolous's application for reinstatement because it raised serious issues that required more evidence than was available at the interim hearing.[396]

This case did not even touch upon the big question of mass immunization. It addressed only the very limited power to immunize health workers on pain of job loss if they refuse. Even this limited power is controversial. Some health workers find it singular and heavy-handed. One nurse said:

> And it is imperative that all preventative measures be emphasized vis-à-vis the singular and heavy handed emphasis on mandatory immunization of staff.

Immunization is an integral part of our public health system[397] which has the benefit of distinguished scientific advice.[398] Ontario leads the way in annual voluntary adult influenza vaccination[399] and its universal influenza vaccination plan has been hailed as a model for the world:[400]

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[396] An arbitration board in *Re St. Peter's Health Systems and Canadian Union of Public Employees, Local 778* (2001), 106 L.A.C. (4th) 170 (Charney), February 7, 2002 dealt with a chronic care geriatric facility public hospital dealing with old and frail inmates. It had 130 full time staff. A hospital regulation directed that if there is a flu outbreak, every staff member would either have a flu shot or Amantadine treatment or would be suspended from work without pay until the outbreak subsides. Fifteen grievors challenged the regulation. The board held that in the absence of a statutory requirement enforced vaccination like any other form of enforced medical treatment, was an assault, relying on the Supreme Court of Canada decision in *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. The opposite result was reached in *Re Carewest and Alberta Union of Provincial Employees* (2001), 104 L.A.C. (4th) 240 (Smith)." where the arbitration board found that the employers policy of enforced vaccination was reasonable. a. "."

[397] Section 5 of the Health Protection and Promotion Act, provides:

> 5. Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:
>
> > 1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
> >
> > 2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults …

> See Ontario's Immunization of *School Pupils Act*, R.S.O. 1990, c. I.1

[398] The Ministry of Health and Long-Term Care established the Provincial Infectious Diseases Advisory Committee (PIDAC) to provide a single standing source of expert advice to the Chief Medical Officer of

> If a country cannot cope with interpandemic influenza, it is likely that the pandemic, when it does occur, will cause massive societal disruption … The steps needed to deal effectively with interpandemic influenza can also help in preparing for an influenza pandemic. The new initiative promoting universal influenza vaccination in Ontario, Canada, can serve as a model for the world. If demonstrated to be effective, it should be expanded to other areas.

Despite this international acclaim, Ontario has not yet solved the limited problem of health worker immunization by order,[401] let alone the bigger problems of mass immunization by order.

Health care workers are the first priority for immunization in every Canadian pandemic plan.[402] If Ontario has not solved the limited problem of health worker immunization by

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Health on infectious diseases for Ontario. PIDAC's immunization subcommittee is chaired by Dr. Ian Gemmill, the Medical Officer of Health for the Kingston, Frontenac and Lennox and Addington Health Unit.

[399] Ontario is the only jurisdiction in North America to make the influenza vaccine available free to all residents. Ontario's universal influenza vaccination programme was announced on July 25, 2000. The province acquired 5.5 million doses of the vaccine for the 2004-5 flu season. According to "The Ontario Experience with Universal Vaccination," a presentation by Dr. Karim Kurji, Associate CMOH, to the National Influenza Summit, Atlanta, Georgia, on April 2004, the programme appears to be increasing immunization rates in priority groups, including health care workers. The presentation stated that before the advent of the universal vaccination program, 20 per cent of hospital staff was immunized. By the 2003-4 flu season, this had risen to 55 per cent.

[400] Institute of Medicine of the National Academies, *Microbial Threats to Health: Emergence, Detection and Response*, (Washington, D.C.: 2003), p. 147.

[401] Ontario is still struggling with the immunization of health workers. A report by Dr. Abraham on the 1998/99 flu season, introduced into evidence in the Kotospoulos case, noted that the desired level of immunization, a target of over 70%, had not been achieved in health care institutions. Recent influenza vaccine coverage data for staff and residents in Ontario hospitals and long term care facilities for 2003/2004 shows that 55% of hospital staff are covered while 84% of long term care staff are covered. (Source: Dr. Karim Kurji, Associate Chief Medical Officer of Health for Ontario, *The Ontario Experience with Universal Vaccination* National Influenza Vaccine Summit, Atlanta, April, 2004.)

[402] The Ontario plan provides in part:

Priority Group	Estimated Number	Rationale	Subgroups

order, is it ready to enact a sweeping power to immunize by order the entire population of 12 million? It is one thing to prove that compulsory vaccination of paramedics is a reasonable limit in a free and democratic society.[403] It is a quantum leap to prove that compulsory vaccination of Ontario's entire population of 12 million is a reasonable limit. If a case for the smaller power has not yet been established, can a case be made out for the much bigger power? Can the Attorney General give the government a legal opinion that any proposal for mass immunization by order complies with the *Canadian Charter of Rights and Freedoms*?

As Dr. Schabas notes above, universal immunization has never before been attempted even on a voluntary basis on the scale currently under way in Ontario. In the event of an influenza pandemic, it raises a host of issues. Will there be enough vaccine?[404] Will every new vaccine be safe? How can safety be ensured?[405] Who gets vaccinated first?[406] Can

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1. Health care workers, emergency medical services, public health workers	140,000 RNs/RPNs, 25,000 physicians, 7,000 public health workers	The health care and public health sectors are the first line of defense in a pandemic. An effective response depends on maintaining these services.	Health care workers in: • acute care hospitals • long term care facilities/nursing homes • private physicians' offices • home care and other community care facilities • public health offices • ambulance and paramedic services • pharmacies • laboratories

[403] *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.) 1982, c. 11* provides as follows:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[404] The objective of the Canadian Influenza Pandemic Plan is to "vaccinate the whole Canadian population over a period of four months on a continuous prioritized basis after receipt of the pandemic seed strain. This would require a minimum of 32 million monovalent doses (8 million doses per month)." For supply line difficulties caused by contamination at a vaccine manufacturing facility in Liverpool producing vaccine for the Chiron Corporation see John Treanor, M.D. Weathering the Influenza Vaccine Crisis N Engl J. Med 351:20 November 11, 2004.

[405] "Mass immunization campaigns pose specific safety challenges, due to their objective of immunizing large populations over a short period of time and often being conducted outside the normal healthcare setting. Two of the most notable challenges are injection safety and adverse events following immunization (AEFI)": Safety of Mass Immunization Campaigns Immunization Safety Priority Project, Department of Vaccines and Biologicals, W.H.O. As the Canadian Immunization Guide states: "No one in the field of public health takes the safety of vaccines for granted. Vaccine safety is an international concern. Information on possible safety concerns is communicated very rapidly among different countries. This careful monitoring ensures that public health authorities can act quickly to address concerns." Canadian Immunization Guide 6th ed 2002 p. 46.

[406] One dilemma was posed by Gregory Poland, chief of the vaccine research group at the Mayo clinic: "Long term care facilities are saying, 'we have 100 residents and 60 health-care workers. We have 100 doses of vaccine. Who should get them?' There's no clear-cut answer." Marilynn Larkin, *Flu Vaccine: Will Scarcity Improve Compliance in USA?* The Lancet Infectious Diseases v. 4 December 2004.

people who are low on the priority list go to court and argue their equality rights are infringed because they are deprived of a benefit given to others?[407] What do you do with people who refuse vaccination; can you legally isolate them or jail them or suspend them from their jobs as health care workers? This last question engages the unresolved legal issues noted above. Any proposal for mass immunization by order must be very explicit about the legal consequences of refusal.

This is not to say that every question must be completely resolved before proceeding. It is simply to say that as soon as any element of compulsion is introduced through an order for immunization, with a consequence like isolation or job suspension for those who refuse, the practical and policy and legal implications must be fully confronted before proceeding.

As for penalty, mass immunization by order is not set out as a power in any Ontario law[408] and disobedience to such an order would attract no penalty. This chapter has referred repeatedly to consequences of refusal such as isolation or, for a health care worker, job suspension. But if mass immunization by order were enacted in Bill 138, the proposed emergencies bill now before the Legislative Assembly, failure to obey an immunization order would be punishable by a fine of up to $100,000.00 and imprisonment for up to one year. If mass immunization by order is enacted as part of a general emergency statute that carries a penalty for noncompliance, it ups the legal ante and requires very careful attention to the exemption procedures.

The most important question of all is whether mass immunization by order is enforceable.[409] If even a small proportion of Ontario's 12 million people decline vaccination, can the government realistically enforce the mass isolation of all those who refuse? Because the success of mass immunization depends on voluntary compliance and public confidence, public education is infinitely more important than legal compulsion.[410]

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[407] Vaccine shortage or apprehended crisis creates demand for immunization. The recent shortage of American influenza vaccine in October of 2004 "…unleashed a veritable frenzy… 'Medical tourism' has been one creative response to the vaccine shortage: Americans are paying U.S. $105 to take the high-speed ferry from Seattle, Washington, to Victoria, British Columbia, or are crossing other borders into Canada to get influenza vaccines." (Source: European Molecular Biology Organization, Reports v. 6 no. 1 2005 p. 13.) The Journal of the American Medical Association Dec. 1 2004 v. 292 No. 21 p. 2582 noted: "Publicity surrounding the shortage has created demand even among lower-risk adults, further threatening the supply for those who need it most."

[408] Although a legal argument might be made that a generous reading of the general powers in the *Health Protection and Promotion Act* could support such an order, that argument would be a real stretch. An argument might also be made that mass immunization by order is authorized under the doctrine of inherent or common law powers discussed below.

[409] The standard enforcement pattern for involuntary medical treatment in the *Health Protection and Promotion Act* requires an individual court hearing for each individual who it is sought to treat. Any proposal for mass immunization by order would have to be very clear as to the exact machinery of enforcement, its efficacy if there were thousands of refusals, and its viability in face of a legal challenge under the *Charter of Rights*.

[410] Gregory Poland, chief of the vaccine research group at the Mayo clinic said of flu vaccine education "Despite 60 years of data on the efficacy and safety of the vaccine, ignorance – no inconvenience or cost – is

The World Health Organization identifies compulsory immunization as a difficult legal issue that requires a legal framework based on a transparent assessment and justification of the measures under consideration.[411]

What is required in any proposal for mass immunization by order, and indeed any other emergency power is an appropriate balance between the public interest in protecting the community from disease and the personal liberty of every individual to refuse state compulsion when fundamental freedoms are engaged.

It may be that a case for mass immunization by order can be made that adequately addresses the fundamental issues noted above. It may be that evidence is available to satisfy the Charter requirement that the measure is reasonably justified in a free and democratic society.[412] It may be that evidence is available to satisfy the WHO requirement that the measure is based on transparent assessment and justification.

Until such evidence has been presented in a comprehensive fashion, it is difficult to say that mass immunization by order, as opposed to a purely voluntary programme, is ripe for enactment at this time as a permanent feature of Ontario's law. Although a purely voluntary scheme would not raise the same issues, proposals for mass immunization by order involve some element of compulsion in the form of a consequence for refusal such as isolation or jail or suspension from work.

It must be emphasized again that every question need not be resolved completely before proceeding with legislation. It is simply to say that as soon as any element of compulsion is introduced through an order for immunization, with a consequence like isolation or jail or job suspension for those who refuse, the practical and policy and legal implications must be

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what keeps health-care workers from being vaccinated. ... We can't continue to let fears and misperceptions prevent us from doing the right thing for our patients." Marilynn Larkin, *Flu Vaccine: Will Scarcity Improve Compliance in USA?* The Lancet Infectious Diseases v. 4 December 2004. See also Carolyn S. Markey, R.N., *Healthcare Worker Influenza Vaccination* Home Healthcare Nurse v. 22 no. 9 September 2004: "Why aren't more of our colleagues being immunized against flu? Reasons for not receiving influenza vaccine cited in several studies include: concern about side effects or vaccine safety, including the misperception that the injectable vaccine could cause the flu; perception of a low personal risk of contracting influenza; inconvenience; ignorance of the CDC recommendations; and dislike of needles. ..."

[411] "During a pandemic, it may be necessary to overrule existing legislation or (individual) human rights. Examples are the enforcement of quarantine (overruling individual freedom of movement), use of privately owned buildings for hospitals, off-license use of drugs, compulsory vaccination or implementation of emergency shifts in essential services. These decisions need a legal framework to ensure transparent assessment and justification of the measures that are being considered and to ensure coherence with international legislation (like the revised International Health Regulations)." (Source: W.H.O., "Influenza Pandemic Preparedness Checklist," (Geneva: November 2004), p. 12.)

[412] For convenience, section one of the Charter is repeated below:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

fully confronted before entrenching compulsory mass immunization as a permanent feature of our law.

If the government thinks that the power to order mass immunization instead of a purely voluntary programme is required in the interests of public safety, its obligation is to bring forward as soon as possible a detailed plan and body of evidence that will enable the Attorney General to give an opinion on the constitutional validity of such a power and to enable the Legislative Assembly and the public to assess its necessity.

If pandemic influenza threatens suddenly, pending the development of such a case, it is open to the government to bring forward an urgent statute with an early sunset clause to get through any immediate threat. There is however no justification to delay the production and presentation of the case for mass immunization by order. As the Justice Policy Committee was advised:

> The time to consider emergencies is when you don't have one.[413]

Recommendations

The Commission therefore recommends that:

- **The power of mass compulsory immunization not be enacted as a permanent feature of Ontario's law until the evidence has been presented in a comprehensive fashion.**
- **Every proposed emergency power, before its enactment, be thoroughly subjected to the legal, practical, and policy analysis exemplified by the above analysis of compulsory mass immunization and that the evidence in support of each power be presented in a comprehensive fashion before enactment.**
- **If the government decides it is necessary to enact any emergency power before there is time to subject it thoroughly to the legal, practical, and policy analysis exemplified by this analysis of compulsory mass immunization, that the government sunset any such provision for a period not to exceed two years in order to provide time for the required scrutiny.**

Bill 138

The government, as noted above, has expressed its intention to proceed with general emergency legislation along the lines suggested in Bill 138, *An Act to Amend the Emergency Management Act and the Employment Standards Act, 2000*, which received first reading on

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[413] John Twohig counsel from the policy branch of the Attorney General's Department, in testimony to Justice Policy Committee, August 19, 2004 on August 19 2004, p. 181.

November 1, 2004 as a private member's bill produced by the Standing Committee on Justice Policy after public hearings.

As noted above the Commission's mandate does not cover general emergency legislation for war, famine, flood, ice storms and power blackouts and the government decision to proceed with Bill 138 is not within the Commission's terms of reference. Because the government has chosen Bill 138 as the vehicle for all emergency legislation including public health emergency legislation the Commission must say something about Bill 138 as a vehicle for public health emergency powers and the government has invited the Commission to do so.[414]

The thoughtful work of the Justice Policy Committee in its hearings and its production of its report and Bill 138 is a matter of public record. It need not be recounted here except to note that the people of Ontario owe a significant debt of gratitude to those members of the Legislative Assembly who worked so hard and to all of those who assisted them.

The strengths of the Committee process are obvious to anyone who has had an opportunity to review its proceedings. Certain legal concerns, flowing largely from the unusual process imposed on the Committee, are addressed in correspondence between the Commission and the government set out in Appendix H. The essence of the Commission's concern is that the unusual process of proceeding to a draft bill of such profound legal importance, without prior policy and operational analysis by departments of government and without prior legal and constitutional scrutiny by the Attorney General deprived the Bill of the solid underpinnings that ordinarily precede the development of any important piece of legislation.

The work initiated by the Justice Policy Committee when they took the discussion draft bill from the Attorney General's Department and considered it in light of the Committee's public hearings must now be completed. A sober second thought is now required. That sober second thought must be informed by the regular processes that the government skipped in its decision to proceed as it did.

As noted above, the first big question about Bill 138 is legal. Does it conform to the Charter and it is clear and workable from a legal point of view? The Commission has no mandate to give legal advice or opinions on the constitutionality of Bill 138 or any of its provisions. These legal questions can only be answered by the Attorney General whose exclusive authority on these questions is set out below.

Ontario's emergency legislation will probably be challenged in court. A lot will be at stake in any court challenge. It will be a major blow to the integrity of the legislation should a court strike down as unconstitutional any part of the statute or any emergency order made under the statute. A successful court challenge in the middle of an emergency could have disastrous effects on the emergency response. A successful court challenge at any time would produce a cloud of uncertainty that might not disperse for years. The first delay in resolving the uncertainty could be the time it takes for a challenge to wend its way from the trial court to the Supreme Court of Canada. The second delay could come from the lengthy cycle that so often ensues when legislation is struck down on Charter grounds, sometimes referred to as a dialogue between the courts and the legislature. The courts strike it down, the legislature makes amendments to conform to the Charter, and then the whole cycle could start again with a new court challenge to the amendments.

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[414] Letter to the Commission from the Minister of Health and Long Term Care and the Minister of Community Safety and Correctional Services, received March 14, 2005 and reproduced in Appendix H.

It is therefore essential to ensure as much as possible that the legislation conforms with the *Canadian Charter of Rights and Freedoms.*

This job is at the heart of the responsibilities of the Attorney General and his Crown Law Officers. Firstly, because it is the responsibility of counsel for the Attorney General to defend any challenge to the legislation or the emergency order. Secondly, the common law and the *Constitution Act, 1867*[415] impose these duties, also set out in the *Ministry of the Attorney General Act,*[416] exclusively on the Attorney General.

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[415] *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c.3, (formerly know as the *British North America Act*).

[416] Ministry of the Attorney General Act R.S.O. 1990, c. M-17 s. 5:

> The Attorney General,
>
> (a) is the Law Officer of the Executive Council;
>
> (b) shall see that the administration of public affairs is in accordance with the law;
>
> (c) shall superintend all matters connected with the administration of justice in Ontario;
>
> (d) shall perform the duties and have the powers that belong to the Attorney General and Solicitor General of England by law or usage, so far as those duties and powers are applicable to Ontario, and also shall perform the duties and have the powers that, until the *Constitution Act, 1867* came into effect, belonged to the offices of the Attorney General and Solicitor General in the provinces of Canada and Upper Canada and which, under the provisions of that Act, are within the scope of the powers of the Legislature;
>
> (e) shall advise the Government upon all matters of law connected with legislative enactments and upon all matters of law referred to him or her by the Government;
>
> (f) shall advise the Government upon all matters of a legislative nature and superintend all Government measures of a legislative nature;
>
> (g) shall advise the heads of the ministries and agencies of Government upon all matters of law connected with such ministries and agencies;
>
> (h) shall conduct and regulate all litigation for and against the Crown or any ministry or agency of Government in respect of any subject within the authority or jurisdiction of the Legislature;
>
> (i) shall superintend all matters connected with judicial offices;
>
> (j) shall perform such other functions as are assigned to him or her by the Legislature or by the Lieutenant Governor in Council. R.S.O. 1990, c. M.17, s. 5.

While the work of the Justice Policy Committee was impressive within the limits of the resources available to it, Bill 138 still requires fundamental review by the Attorney General before it can get a clean bill of health, legally and constitutionally. As noted above, the Attorney General has indicated that he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements. See the letter to the Commission of March 14, 2005 from the Minister of Health and Long-Term Care and the Minister of Community Safety and Correctional Services.

The job of the Attorney General is never an easy one because of the independent quasi-judicial duties associated with that office, and the independent constitutional obligation to ensure that both government legislation and government action are conducted according to law. This can bring the holder of that office into conflict with the political agenda of the government.[417] Fortunately this province has a strong tradition that the Attorney General stands up for what is legally right whether or not it is politically expedient and that the government takes the Attorney General's advice on matters having to do with the legal and constitutional integrity of government legislation and government action. No Cabinet can be reminded too often that any government that ignores the Attorney General's advice does so at its peril.

That is why the Attorney General's review of Bill 138 is so fundamentally necessary in order to give the members of the Legislative Assembly and the public the assurance of legal and constitutional integrity.

The second big question about Bill 138 is whether it covers all the powers that might reasonably be required in a public health emergency or the public health aspects of a wider emergency. Does Bill 138 provide adequate legal authority for the operational measures that may reasonably become necessary in an emergency? The operational aspects of these questions can only be answered by those government departments that have to make the legislation work in the field when an emergency strikes. The legal aspects of these questions, once more, can only be answered by the Attorney General.

Because it would be unwise for the reasons noted above to have one set of laws for public health emergencies and a different set of laws for all other emergencies, and because the government has chosen Bill 138 as the vehicle for emergency laws, Bill 138 requires examination to ensure that it contains all the authority necessary to deal with public health emergencies. These specific public health emergency powers, listed above, must be reviewed operationally within government to see if they are necessary and to see if further specific powers are required. Once the government has decided what powers are required for public health emergencies, the Attorney General must examine the powers in Bill 138 to see if they cover what is needed or if they require expansion to deal with the identified needs of public health emergencies.

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[417] This is one reason why Sir Patrick Hastings, a former Attorney General for the United Kingdom said "Being an Attorney General as it was in those days is my idea of hell." Sir Patrick Hastings. *The Autobiography of Sir Patrick Hastings*, London, William Heinemann 1948 at p. 236. The first lesson learned by every new Attorney General is the cautionary tale of Hastings, a rising political star and brilliant lawyer whose political career ended in ruins in 1924 when the government fell because he allegedly took political advice from the government about the conduct of a criminal prosecution As a later Attorney General put it: "The truth of the allegations remains disputed but this case has long served as a warning to later Law Officers and to governments." As Dingle Foot, Solicitor General during the Wilson administration put it quite simply: 'The Campbell case should have taught governments not to interfere with the Law Officers.' *Politics, Public Interest and Prosecutions – A View by the Attorney General* 13th Annual Tom Sargent Memorial Lecture: An address by the Right Hon. The Lord Goldsmith, Q.C., Her Majesty's Attorney General, London, 20 November 2001.

One example of the many issues that require legal and policy analysis is the problem of legal liability from lawsuits arising out of emergency action.

The problem of personal liability under the *Health Protection and Promotion Act* is addressed above, in Chapter 1, in respect of extending to the Chief Medical Officer of Health and all professional advisers and public health workers the same personal protection now afforded to the medical officer of health by s. 95 of the *Health Protection and Promotion Act.* The differences between this form of liability protection, the liability protection suggested in the discussion draft bill from the Attorney General's Department, and the liability protection suggested in Bill 138 are noted above. While these issues are legally complicated, people and organizations who help out in an emergency either voluntarily or by responding to an emergency order are entitled to know where they stand. Concerns about liability were put to the Commission by a number of organizations:

> … it would be most helpful to have legislation that limits claims brought forward as a result of actions taken by employers at the direction of the defined authority in emergency situations.
>
> ---
>
> Protection from liability for health care sector providers and government authorities with respect to acts performed in good faith in responding to the emergency, and in implementing health emergency plans.
>
> ---
>
> If nurses are expected to follow specific government, hospital or other orders during an emergency, they should be provided immunity from disciplinary, civil and other legal proceedings. We recommend that nurses be provided such immunity where their conduct constitutes a good faith attempt to carry out an order in an emergency.

The issue of liability during an emergency was also raised by Dr. Bonnie Henry, in her submissions before the Justice Policy Committee:

> If I could make a comment on that, I think one of the things we learn over and over again in a crisis is that you can never do just enough. If you stop the outbreak, you've done way too much and you overreacted; if you don't stop the outbreak, you clearly didn't do enough. I don't think there's any way to legislate the ability to do things in good faith. It's a really difficult situation that we're put into. We're now dealing with at least three class-

> action lawsuits, none of which, thankfully, has been certified yet and all of which name the city of Toronto for doing too much. I'm actually quite proud of doing too much, the perception that we did too much. I think we did what we needed to do under very trying circumstances, and understanding that the need to protect people from lawsuits for doing what they feel is right and what is supported as right or – I'm not being very articulate – what is being done to the best of their ability and knowledge to try and control a situation that's extremely dangerous, needs to be enshrined in legislation. People who are asked by the government to help, to provide advice, whether their advice is taken or not, need to be protected from liability. I don't think the Good Samaritan Act is the same concept. I think the Good Samaritan Act is pretty good, for what it does. It protects people for different situations.[418]

Whatever competing model the government decides to take in respect of protection against liability from lawsuits, concerns such as those expressed above must be addressed one way or the other. Whatever the government's choice, those who express these concerns are entitled to know exactly where they stand.

All the Commission can do, lacking any mandate in respect of general emergency legislation like Bill 138, is to point to some problems with Bill 138 as a vehicle for public health emergency problems and to identify some areas where the Bill 138 powers may not provide all the authority necessary.

Bill 138: Power to Override Ontario Laws

Bill 138 provides, with one exception,[419] that emergency orders prevail over every other Ontario law. Subsection 7.0.6 (1) provides:

> In the event of a conflict between an order made under section 7.4 and any statute, regulation, rule, by-law or order, the order under section 7.4 prevails.

This power is awesome. One provincial official described it, accurately, as grandiose. An emergency order could override laws such as the *Habeas Corpus Act,*[420] the *Legislative Assemby Act,*[421] the *Human Rights Code,*[422] the *Elections Act,*[423] and the *Courts of Justice Act.*[424] An emergency order could override any law that promotes the public good or protects individual rights. Any such proposal requires the most searching scrutiny.[425]

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[418] Justice Policy Committee, Public Hearings, August 18, 2004, p. 158.

[419] The sole exception is the *Occupational Health and Safety Act*, R.S.O. 1990, c. O-1 discussed below.

[420] R.S.O. 1990, c. H-1.

[421] R.S.O. 1990, c. L-10.

[422] R.S.O. 1990, c. H-19.

[423] R.S.O. 1990, c. E-6.

The override power in Bill 138 is not only awesome but it also differs significantly from the approach in other emergency statutes.[426]

Not all provincial emergency statutes contain clear override provisions. See for instance Saskatchewan's *Emergency Planning Act*[427] and New Brunswick's *Emergency Measures Act.*[428] It would be helpful to be provided with a full legal analysis by the Attorney General of the extent to which the emergency legislation of other provinces contains override provisions and how such provisions compare with those in Bill 138.

To take one example of the kind of analysis required, the override provisions in the emergency legislation of Manitoba and Alberta, by explicit language, limit the overrides to other legislation of the provincial legislature.

Manitoba's *Emergency Measures Act,*[429] provides that where there is a conflict between an emergency order of the minister and "a provision of, or an order made under, any other Act of the Legislature," the minister's order prevails. Alberta's *Disaster Services Act,*[430] is particularly notable in that s. 18(5) first confines the override to other provincial statutes, and then excludes certain of those statutes from the override:

> 18(5) Unless otherwise provided for in the order for a declaration of a state of emergency, where
>
> (a) an order for a declaration of a state of emergency is made, and
>
> (b) there is a conflict between this Act or a regulation made under this Act

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[424] R.S.O. 1990, c. C-43.

[425] In Robert Bolt's play "A Man for All Seasons" Sir Thomas More makes a famous plea for the protection of laws as a shelter for the nation and its people:

> "This country's planted thick with laws from coast to coast … and if you cut them down …d'you really think you could stand upright in the winds that would blow then?"

[426] This is a convenient place to note that Ontario's existing emergency management act contains a limited power for the government to override temporarily laws that set limits for compensation and benefits, in order to provide more services, benefits, or compensation to victims of an emergency than the limits ordinarily imposed in non-emergency situations. *Emergency Management Act* R.S.O. 1990, c. E-9, s. 7.1 (7).

[427] S.S. 1989-90, c. E-8.1.

[428] S.N.B. 1978, c. E-7.1.

[429] C.C.S.M. c. E-80, s. 21(2).

[430] R.S.A. 2000, c. D-13.

> and any other Act or regulation, other than the *Alberta Bill of Rights* or the *Human Rights, Citizenship and Multiculturalism Act* or a regulation made under either of those Acts,
>
> this Act and the regulations made under this Act, during the time that the order is in effect, shall prevail in Alberta or that part of Alberta in respect of which the order was made.

The override power in Bill 138 is less clear. Does the word "rule" in s. 7.0.6(1) reflect an intention to override rules of common law? If not, this should be made clear. Does the word "order" in s. 7.0.6(1) reflect an intention to override the order of a court or labour tribunal or Human Rights tribunal or of the Legislative Assembly? If not, this should be made clear.

Another issue is the extent of the double override in Bill 138 in respect of the power to compel from any person any information that is thought by the government to be necessary for emergency management. Bill 138 provides that emergency orders may be made in respect of such compulsory disclosure:

> 7.0.2(4) 11. Subject to subsection (9), the requirement that any person disclose information that in the opinion of the Lieutenant Governor in Council may be necessary in order to prevent, respond to or alleviate the effects of the emergency.
>
> …
>
> 7.0.2(9) The following rules apply with respect to an order under paragraph 11 of subsection (4):
>
> 1. An order prevails over any other Act or regulation.
> 2. Information that is subject to the order must be used to prevent, respond to or alleviate the effects of the emergency and for no other purpose.
> 3. Information that is subject to the order that is personal information within the meaning of the *Freedom of Information and Protection of Privacy Act* shall be destroyed as soon as is practicable after the emergency is terminated.

This power to compel anyone to disclose any information demanded by the government raises two concerns.

One concern is technical. It is unclear why the power to compel information inserts a limited override (s. 7.0.2 (9) 1.) into a wider override (7.0.6 (1)). It is doubly unclear to the point of confusion why the two overrides are different. The information override prevails over any other Act or regulation. The wider override prevails over any statute, regulation, rule, by-law or order. It is a mystery why the language of the two overrides is different. It is unclear whether they work together or which one prevails in case of conflict.

The more important concern is the extent of the power to compel anyone to disclose any information demanded by the government. On its face it would apply to the confidential sources of journalists and to confidential information entrusted to lawyers by their clients. It may be argued on the basis of general legal principles that the power does not override any common law privilege against disclosure. But Bill 138 does not say so. If Bill 138 does not compel disclosure of confidential journalistic sources or solicitor client confidences, either Bill 138 should say so or the Attorney General should say so. It is essential before Bill 138 is enacted that people know whether they may refuse to disclose confidential information or the identity of its source or whether, if they refuse to disclose it, they will be liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.[431]

It seems reasonable to provide some kind of override. If you have to empty out a hospital to make room for SARS cases and send some patients immediately to long-term care facilities, it makes sense to override temporarily the patients' right to consider and ponder and choose which long-term care facility they prefer.

Specific examples of the need for such override were brought to the Commission's attention in a series of submissions from organizations who addressed the question in light of the lessons they learned in SARS. Concerns about any power to override collective agreements and safety regulations are addressed specifically below. What this list provides is evidence that those who will have to respond to a future emergency need clarity in respect of any override provision:

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[431] Subsection 7.0.12(1) provides:

> (1) Every person who fails to comply with an order under subsection 7.0.2(4) or who interferes with or obstructs any person in the exercise of a power or the performance of a duty conferred by an order under that subsection is guilty of an offence and is liable on conviction,
>
> > (a) in the case of an individual, subject to clause (b), to a fine of not more than $100,000 and for a term of imprisonment of not more than one year;
> >
> > (b) in the case of an individual who is a director or officer of a corporation, to a fine of not more than $500,000 and for a term of imprisonment of not more than one year; and
> >
> > (c) in the case of a corporation, to a fine of not more than $10,000,000.
>
> Separate offence
>
> (2) A person is guilty of a separate offence on each day that an offence under subsection (1) occurs or continues.
>
> Increased penalty
>
> (3) Despite the maximum fines set out in subsection (1), the court that convicts a person of an offence may increase a fine imposed on the person by an amount equal to the financial benefit that was acquired by or that accrued to the person as a result of the commission of the offence.

> Specific legislation that clearly defines which act supersedes another in given situations will be important. For example, does the need to access personal health information during outbreak conditions supersede the Privacy Legislation?
>
> ---
>
> The relevant pieces of legislation need to make clear which legislation takes precedence, for example Occupational Health and Safety versus Privacy versus Emergency measures.
>
> ---
>
> Clear indications of when and how provisions of the emergency health legislation would trump other legislation enactments that apply to the health care sector in non-emergency situations …
>
> … we consider it particularly important that health emergency legislation consider how the legal duties of public hospitals and other health providers, as provided for in other legislation, will be temporarily suspended during the emergency. Any change in "normal" legal duties must be made with a view to facilitating the most efficient, objective, and scientifically supported response to the emergency. Particular statutes of importance to the hospital sector that must be considered include, among others:
>
> 1. Public Hospitals Act and its regulations, especially the Hospital Management Regulation;
> 2. Various employment-related statutes, such as the *Occupational Health and Safety Act*;
> 3. Commitment to the Future of Medicare Act, 2004 (Bill 8);
> 4. *Personal Health Information Protection Act, 2004*, sections 1 - 72 of which come into force on November 1, 2004;
> 5. Regulated Health Professsionals Act, 1991 and related professions Acts; and
> 6. Health Protection and Promotion Act.
>
> ---
>
> Legislative power should be integrated for the duration of the emergency to enable directives at all jurisdictional levels at the declaration of a state of

> emergency by the federal parliament or provincial legislature. Such legislation needs to suspend the responsibilities of health care facility Boards of Directors under, for example, the Corporations Act and collective agreements, for the duration of the emergency.
>
> ---
>
> Suspension of legislative/regulatory requirements – Any emergency legislation must clearly provide for the suspension of existing legislative and regulatory requirements, where appropriate. For example, during SARS, the challenge of discharging patients to long-term care facilities was exacerbated by regulatory requirements that stipulate that transfers could not be made to facilities that were not on the patient's list of preferred facilities.
>
> ---
>
> Legislation should specifically provide that the declaration of a provincial emergency and/or special health emergency does not suspend collective agreements. The parties to collective agreements should be required to comply with them, subject to terms that are specifically negotiated under an emergency plan …
>
> ---
>
> … There should be specific provisions stating that the declaration of an emergency and/or special health emergency does not permit the circumvention of occupational health and safety obligations and legislation.
>
> ---
>
> Legislation should specifically provide that the declaration of a provincial emergency and/or special health emergency does not abrogate any legal rights, except those expressly identified. While the declaration of an emergency does not currently suspend collective agreements or otherwise limit employees' rights, hospitals took that position during the SARS crisis and, accordingly, a specific legislative provision is required …
>
> … It should be specifically provided that the declaration of an emergency and/or special health emergency does not permit the circumvention of occupational health and safety obligations and legislation.

This is a convenient place to note that Bill 138 makes no reference to collective agreements. The draft discussion bill provided to the Justice Policy Committee by the Attorney General's Department contained an explicit provision that emergency orders would override collective agreements.[432] That power is strikingly absent from Bill 138.[433] Bill 138 neither expressly overrides collective agreements in the manner proposed in the draft discussion bill, nor expressly preserves them from the general override in s. 7.0.6(1) as it does with occupational health and safety laws. It may be that Bill 138 leaves collective agreements in limbo. It is a legal question, whether or not the present override in Bill 138 would override collective agreements through the power to override statutes that provide for collective bargaining rights. This is an issue too important to leave to legal debate once an emergency arises. It must be clear to employers and employees whether or not emergency orders override collective agreements. This is another legal area that requires clarification from the Attorney General.

The Commission therefore recommends that the Attorney General, in the review of Bill 138, clarify whether or not the override power in s. 7.0.6(1) affects collective agreements.

In one particular respect the override power is deficient and dangerous. It is not reasonable to override the foundational laws that underpin Ontario's democratic legal system including laws such as the *Habeas Corpus Act*,[434] the *Legislative Assembly Act*,[435] the *Human Rights Code*,[436] the *Elections Act*,[437] and the *Courts of Justice Act*.[438] The line might not be perfectly clear in respect of every statute. The *Elections Act*[439] is a good example. Alberta provides a power to delay an election for up to three months in face of a disease epidemic or other public health emergency.[440] It is a political question for the government and the Legislative Assembly

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[432] Section 7.4(10) provides: "No contract, collective agreement, lease, license or other non-legislative instrument shall be interpreted so as to prevent the carrying out of an order under this section."

[433] The Justice Policy Committee may have addressed the issue indirectly when it said in its Report: "In a declared emergency … it is necessary to ensure that help is available, while at the same time acknowledging: (i) statutory and contractual employment, labour and occupational health and safety standards … ." … "The Committee recommends that the government seek to facilitate the development of protocols under which management and employees can deal with the extraordinary circumstances of an emergency." See: Standing Committee on Justice Policy, *Report on the Review of Emergency Management Law in Ontario*, (November 2004), p.7

[434] R.S.O. 1990, c. H-1.

[435] R.S.O. 1990 c. L-10.

[436] R.S.O. 1990 c. H-19.

[437] R.S.O. 1990, c. E-6.

[438] R.S.O. 1990, c. C-43.

[439] R.S.O. 1990, c. E-6.

[440] *Public Health Act*, R.S.A. 2000, c. P-37, s. 38(1)(b).

> 38 (1) Where the Lieutenant Governor in Council is satisfied that a communicable disease referred to in section 20(1) has become or may become epidemic or that a public health emergency exists, the Lieutenant Governor in Council may do any or all of the following:
>
> > (a) order the closure of any public place;

exactly how far the override should intrude into foundational legal statutes such as the *Elections Act*. The Commission recommends thorough scrutiny and amendment of the override provision to protect our foundational legal statutes against emergency override.

The override goes to the essential character of the powers themselves and should be tightly connected with them through its position in the statute. It should not be necessary to comb through the statute to find this extraordinary power, now relegated to an obscure position in the statute some 20 provisions after the grant of power. The Commission recommends that this override power be given a more prominent place in the statute by putting right after the enumerated powers.

The Commission recommends that the Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.[441]

Recommendations

The Commission therefore recommends that:

- **The Attorney General in the review of Bill 138 clarify whether or not the override power in s. 7.0.6(1) affects collective agreements.**
- **The Attorney General undertake a thorough scrutiny and amendment of the override provision to protect our foundational legal statutes such as the *Habeas Corpus Act*,[442] the *Legislative***

> (b) subject to the Legislative Assembly Act and the Senatorial Selection Act, order the postponement of any intended election for a period not exceeding 3 months;
>
> (c) in the case of a communicable disease order the immunization or re-immunization of persons who are not then immunized against the disease or who do not have sufficient other evidence of immunity to the disease.
>
> (2) Where an election is postponed under subsection (1), the order shall name a date for holding the nominations or polling, or both of them, and nothing in the order adversely affects or invalidates anything done or the status of any person during the period of time between the date of the order and the completion of the election.
>
> (3) Where a person refuses to be immunized pursuant to an order of the Lieutenant Governor in Council, the person shall be subject to this Part with respect to the disease concerned as if the person were proven to be infected with that disease.

[441] For vagueness, see for instance Gonthier J. in *R. v. Nova Scotia Pharmaceutical Society* [1992] 2 S.C.R. 606 at para 69. For delegation of plenary discretion, see for instance *Irwin Toy Ltd. v. Quebec (A.G.)* [1989] 1 S.C.R. 927 at para 63.

[442] R.S.O. 1990, c. H-1.

***Assembly Act,*[443] the *Human Rights Code,*[444] the *Elections Act,*[445] and the *Courts of Justice Act*[446] against emergency override.**

- **It be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.**

- **The override power be given a more prominent place in the statute by putting right after the enumerated powers.**

- **The Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.**

Bill 138: Trigger, Criteria and Limitations

Bill 138 provides for the making of a declaration of emergency, and for the exercise of emergency powers contingent on such a declaration. Both the declaration of emergency, the "trigger", and the ensuing power to make orders are hedged around with conditions and requirements.

The trigger conditions which are set out in s.7.0.1(3):

> Declaration of emergency
>
> 7.0.1 (1) Subject to subsection (3), the Lieutenant Governor in Council or the Premier, if in the Premier's opinion the urgency of the situation requires that an order be made immediately, may by order declare that an emergency exists throughout Ontario or in any part of Ontario.
>
> ---
>
> Criteria for declaration

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[443] R.S.O. 1990, c. L-10.

[444] R.S.O. 1990, c. H-19.

[445] R.S.O. 1990, c. E-6.

[446] R.S.O. 1990, c. C-43.

> (3) An order declaring that an emergency exists throughout Ontario or any part of it may be made under this section if there is an emergency that is such that,
>
> (a) it requires immediate action to prevent, reduce or mitigate a danger of major proportions that could result in serious harm to persons or substantial damage to property; and
>
> (b) the action cannot be undertaken using the resources normally available to a ministry of the Government of Ontario or an agency, board or commission or other branch of the government.

These provisions represent a clear intention to place reasonable limits on the exercise of emergency powers. What is not so clear is why the author chose these particular legal drafting techniques. As a Yale law professor noted,

> Drafting these provisions is a tricky business.[447]

What is most striking about the trigger provisions is the way in which they combine subjective and objective conditions. On the one hand, subsection (1) requires subjective condition that the decision-maker be of the "opinion" that a situation is sufficiently urgent to require a declaration of emergency. On the other hand, subsection (3) then imposes two objective "criteria": the emergency must be such that "immediate action" is required, *and* it must be such that action cannot be taken using the resources normally available. In other words, before an emergency can be declared, the decision-maker must not only be satisfied that an emergency exits, he or she must also attempt to establish both that the threat is such as to require immediate action, and that the action "cannot be undertaken using the resources normally available," whatever may be meant by that ambiguous phrase.

The trigger provision used in Bill 138 can be contrasted with the trigger provisions found in other emergency statutes. For example, Alberta's *Disaster Services Act*[448] simply requires (at s. 18(1)) that the Lieutenant Governor be "satisfied" that an emergency exists or may exist before a declaration to that effect can be made. A similar approach is adopted in British Columbia's *Emergency Program Act.*[449] Subsection 9(1) provides that once the Minister or Lieutenant Governor in Council is "satisfied" that an emergency exists, a declaration of emergency can be made.

The objective criteria surrounding the trigger power in Bill 138 are not only unusual, they are also problematic. Not only will valuable time be lost in attempting to satisfy the criteria, it will probably be lost in a pointless exercise. Even if the decision-maker had the luxury of time, would it always be possible, before the fact, to determine that "immediate action" is indeed required to prevent "a danger of major proportions"?

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[447] Bruce Ackerman, Sterling Professor of Law and Political Science, Yale University, The Emergency Constitution (2004) 113 Yale Law Journal 1029 at p. 1058.

[448] R.S.A. 2000, c. D-13.

[449] R.S.B.C. 1996, c. 111.

These problems noted above reappear when one turns from the emergency trigger to the emergency powers. The conditions surrounding the exercise of the principal powers are set out in s. 7.0.2(2):

> Criteria for emergency orders
>
> 7.0.2 (2) If an emergency is declared under section 7.0.1, the Lieutenant Governor in Council may make such orders as the Lieutenant Governor in Council considers necessary and essential in the circumstances to prevent, reduce or mitigate serious harm to persons or substantial damage to property,
>
> (a) if the harm or damage will be alleviated by the order; and
>
> (b) if there is no reasonable alternative to the order.
>
> Limitations on emergency order
>
> (3) Orders made under this section are subject to the following limitations:
>
> 1. The actions authorized by an order shall be exercised in a manner which limits their intrusiveness. …

Two features of these provisions are worth noting. First, s. 7.0.2(2) effectively establishes a second set of barriers to the making of an emergency order. In other words, before making an emergency order, the Lieutenant Governor must not only satisfy the conditions attaching to the declarations of an emergency as set out in s. 7.0.1(3), he or she must also satisfy the conditions which attach to the making of emergency orders as set out in s. 7.0.2(2).

Second, the conditions imposed on the making of an emergency order use a mixture of subjective and objective standards. In this connection two observations may be made:

- The exercise of the power itself is purely subjective ("considers necessary and essential") with no requirement of objective reasonableness (such as "on reasonable grounds") or even subjective reasonableness (such as "he considers reasonable"); and
- The limitations on the power are objective and very strict. They require not that the orders be based on reasonable grounds, but that they be objectively correct in the sense that it must be objectively proven that the harm or damage will in fact be alleviated by the order and it must be objectively proven that there is no reasonable alternative to the order.

The strategy adopted in Bill 138 can be contrasted to the strategy used in other jurisdictions.

As has been noted, Alberta's *Disaster Services Act*[450] requires (at s. 18(1)) that the Lieutenant Governor be "satisfied" that an emergency exists or may exist. However, once the subjective condition surrounding the declaration has been satisfied, and the declaration has been made, no further conditions are imposed on the making of emergency orders. The power to make orders is conferred on the designated Minister, and s. 19(1) provides that he or she "may do all acts and take all necessary proceedings including the following …."

Again, as has been noted, British Columbia's *Emergency Program Act*[451] requires (at s. 9(1)) that once the Minister or Lieutenant Governor in Council is "satisfied" that an emergency exists before a declaration to that effect can be made. Thereafter the Minister is free (pursuant to s. 10(1)) to make an emergency order at his or her discretion; no further conditions need be satisfied.

The approach adopted in these jurisdictions ensures that once the decision-maker meets the precondition to the making of a declaration of emergency, he or she is then free to respond in the manner dictated by the circumstances of that emergency, without first ensuring that a further set of conditions is met.

The approach adopted in the emergency portion of Saskatchewan's *Public Health Act*[452] is more structured. The Minister is empowered to issue a remedial order where he or she "believes, on reasonable grounds" both that a serious public health threat exists, and that the order is necessary to remedy the threat.

The strategy adopted in Ontario's Bill 138 is different yet again. In one respect it is closer to that adopted in Saskatchewan's *Public Health Act 1994*, than to that adopted in Alberta's *Disaster Services Act* or British Columbia's *Emergency Program Act*: having declared an emergency, Ontario's Lieutenant Governor in Council must then satisfy further conditions before making an emergency order. However, unlike Saskatchewan's statute the conditions imposed employ not only subjective, but also, as noted above, objective requirements. Therein lies the problem. This approach will make it difficult, in some cases impossible, to say whether or not any given order is legal. Because of course it is impossible to tell in advance whether, to use the language of s. 7.0.2(2), the harm will be "alleviated," or whether there is "no reasonable alternative."

The objective requirements imposed by s. 7.0.2(2)(a) and (b) require perfect prescience on the part of the emergency decision-maker. Although hindsight may be 20-20, it will be impossible for any Premier or cabinet minister to be sure in advance that he or she is perfectly right in what they propose to do. And this is likely to be especially true in the circumstances in which the decision to invoke the power will be made. In the heat of an emergency, like the fog of war, things are not always clear. Is the virus spreading? Do a cluster of patients have SARS or something else? Is it necessary or reasonable to close a hospital even though the extent of simmering undiagnosed disease is yet unclear? What are the risks if the disease spreads into the community because the hospital remains open? Emergencies present risks of unknown proportion and solutions of uncertain success. To require objective correctness is to require the impossible and to straitjacket emergency officials who may need to act very quickly in face of a threat of unknown proportions. No lawyer and no judge would be able to say whether or not any particular emergency order under Bill 138 is or is not legal within the strict limits of its strict criteria.

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[450] R.S.A. 2000, c. D-13.

[451] R.S.B.C. 1996, c. 111.

[452] S.S. 1994, P-37.1.

Similar problem flows from the requirements set out in s. 7.02 (3) 1 and 2. The former provides that actions authorized by an order "shall be exercised in a manner which limits their intrusiveness." Not only is this requirement objective, it is also ambiguous. The latter provides that an order shall only apply to the areas of the Province "where it is necessary." Once more the standard is objective and therefore impossible to implement. An order that appears reasonable and necessary in the face of an unknown threat may prove, after the fact, to have been unnecessary. It is not fair to judge emergency actions solely on the basis of hindsight.

The problems with objective standards of this sort are apparent. They not only require great powers of prescience but they also ignore the practical realities of emergency management. As noted above, the precautionary principle and the hard earned lessons of the past tell us that it may be necessary to overreact in face of a threat that turns out later to be less serious than anyone thought at the time.

The application of an objective standard not only hinders emergency response but it also invites lawsuits based on hindsight that unfairly judges the emergency responder not on what he or she did at the time, but on what turned up later, after the dust had settled.

To enact an objective trigger for an emergency declaration, and objective limitations for the exercise of emergency authority is to ignore the problem of hindsight. Objective standards require courts, when judging the legality of emergency action afterwards, to examine the declaration and the orders in hindsight on the basis of what proved later to be actually necessary rather than judging them on the basis of how things reasonably appeared at the time. In the fog of emergency, like the fog of war, objective standards do not work. As one military historian noted:

> Once a dramatic event takes place, it always appears to have been predictable because hindsight tells the historian which clues were vital, which insignificant, and which false. The unfortunate general who must act without the benefit of hindsight is much more likely to err.[453]

To take an example closer to home, Dr. Young at the SARS Commission public hearings addressed the problem that an emergency may require decisive action in the face of many unknown facts:

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[453] Steven E. Woodworth, *How Good a General Was Sherman?* North and South v. 7 no. 2, March 2004.

> … when we called the provincial emergency, we were dealing with an outbreak where we did not know for sure that it was a virus, we did not know for certainty what virus it was, we did not know what symptoms and what order of symptoms SARS presented with. We had a vague idea that some of the symptoms might include fever and cough. We did not, for example, for some period of time, realize that about 30 per cent of patients also could present with diarrhea. We did not know how long it incubated for. We did not know with certainty whether it was droplet spread or whether it was airborne. We did not know when it was infectious. We did not have a diagnostic test for it and still do not have an accurate diagnostic test. We had no way of preventing it, we had no vaccine and we had no treatment. What we had was an illness with many unknowns and virtually no knowns.[454]

Objective standards of the kind imposed by Bill 138, as noted above, prevent the application of the precautionary principle, so vital to public protection and so strongly relevant to public health emergencies:

> The absence of full scientific certainty shall not be used as a reason for postponing decisions where there is a risk of serious or irreversible harm.[455]
>
> ---
>
> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.[456]

This is not to suggest that conditions should not be imposed on the use of emergency powers. Conditions will however be more realistic if, as in the case of Saskatchewan's *Public Health Act*, they have a subjective focus on what the decision-maker might reasonably be expected to know or understand in the circumstances. When a community defends itself against an apparently deadly threat of unknown proportions it cannot be expected to weigh its response with precision.

A helpful analogy can be drawn to the traditional direction given to juries in cases of self defence:

> … a person defending himself cannot weigh to a nicety the exact measure of his necessary defensive action. If a jury thought that in a moment of unexpected anguish a person attacked had only done what he honestly and

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[454] SARS Commission, Public Hearings, September 30, 2003, p. 34.

[455] Privy Council of Canada, *A Framework for the Application of Precaution in Science-based Decision Making About Risk* (Ottawa: 2003), p.2

[456] *Commission of Inquiry on the Blood System in Canada*. Final Report at page 295, see also pp. 989-994.

> reasonably thought was necessary that would be the most potent evidence that only reasonable defensive action had been taken.[457]

Again and again judges have told juries in cases of self defence that it is not fair to judge defensive action by objective standards alone. Words like the following have been used:

> None of us can measure with any precision what degree of force is excessive or what degree of force we have to use to protect ourselves or someone else. It all depends on what is happening at the time and what we reasonably think is happening. An American Chief Justice said that detached reflection cannot be demanded in the face of an uplifted knife. An English Chief Justice said that one does not use jeweller's scales to measure reasonable force. As our own Supreme Court says, a person who reasonably feels threatened with serious bodily harm or death cannot be expected to weight with nicety the exact measure of responsive force.

The actions of public officials who defend us against emergencies should be judged by no harsher standards than the actions of those who defend themselves against personal aggression.

The test should not be whether an emergency action turns out in hindsight to have been necessary. The test should be whether the emergency action was taken in the honest and reasonable belief that it was necessary in the circumstances as they appeared at the time.

With respect to the precise content of the suggested standard, some guidance can be found in the legal concept of "reasonable apprehension," a concept which has stood the test of time. It is the underlying principle that governs the extent of police powers. In an often quoted passage setting out the extent of police power to take action to protect the public, it was described in the following terms:

> The first duty of a constable is always to prevent the commission of a crime if a constable reasonably apprehends that the action of any person may result in a breach of the peace, it is his duty to prevent that action. It is his general duty to protect life and property, and the general function of controlling traffic on the roads is derived from this duty.[458]

Although closely connected to the concept of reasonable and probable grounds, the test of reasonable apprehension focuses more on the reasonableness of the officer's belief than the existence of objective proof that his belief is in fact correct. See, for instance, Schroeder J.A. in *R. v. Joseph Advent* [1957] O.J. no. 442:

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[457] J. C. Smith, *Justification and Excuse in the Criminal Law*, Hamlyn Trust 1989 p. 108; quoting Lord Morris of Borth Y Gest in Palmer [1971] 1 All E.R. 1077 at 1088.

[458] *Halsbury's Laws of England*, 3rd ed., vol. 30 p. 129. This passage has been quoted in countless cases including *R. v. Waterfield et al.*, [1964] 1 Q.B. 164, per Lord Widgery at p. 188. The latter was, for years, the leading English case on police powers and is to this day invoked regularly in Canada. See *R. v. Clayton* [2005] O.J. No. 1078, (C.A.), per Doherty J.A. at para 35.

> One of the principal duties of a police officer is to prevent breaches of the peace which he reasonably apprehends and the important question in this case is whether or not there were reasonable and probable grounds for the police to entertain the belief that the accused and those with whom he was associated were about to commit a breach of the peace or that there was danger of their committing an assault on the drivers of the approaching trucks if their conduct was not controlled.

Recommendation

The Commission therefore recommends that:

- **The structure and content of the limitations and criteria for the declaration of emergency and the exercise of emergency powers be reviewed with a view to the development of a standard based on the decision-maker's reasonable apprehension that the exercise of the power is necessary in the circumstances.**

Bill 138: Power to Implement Emergency Plans

The power in s. 7.0.2 (4) 1. to "implement emergency plans"[459] is at best ambiguous and at worst lacking in transparency. A close examination suggests that it may confer powers intended by no one.

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[459] "The implementation of any emergency plans formulated under section 3, 6, 8 or 8.1." incorporates by reference the contents of the plans formulated under sections 3, 6, 8, or 8.1. Section 3 (1) provides that "Every municipality shall formulate an emergency plan governing the provision of necessary services during an emergency and the procedures under and the manner in which employees of the municipality and other persons will respond to the emergency and the council of the municipality shall by by-law adopt the emergency plan." Section 6 which provides that every Cabinet Minister and every agency head shall formulate an emergency plan "governing the provision of necessary services during an emergency and the procedures under and the manner in which Crown employees and other persons will respond to the emergency. Section 8, the nuclear emergency section provides that Cabinet shall "formulate an emergency plan respecting emergencies arising in connection with nuclear facilities." Section 8.1 provides a wide power in the Solicitor General to "formulate emergency plans" in respect of non-nuclear emergencies. All of these powers to "formulate emergency plans" come home to roost in the acutal details of what gets written into these plans. Section 9 provides what a plan may provide:

> 9. An emergency plan formulated under section 3, 6 or 8 shall,
>
> (a) in the case of a municipality, authorize employees of the municipality or, in the case of a plan formulated under section 6 or 8, authorize Crown employees to take action under the emergency plan where an emergency exists but has not yet been declared to exist;
>
> (b) specify procedures to be taken for the safety or evacuation of persons in an emergency area;

The section provides:

> (3) the Lieutenant Governor in Council may make orders in respect of the following:
>
> > 1. The implementation of any emergency plans formulated under section 3, 6, 8 or 8.1.

Although it is true that emergency statutes commonly contain a provision such as this, a plain reading raises the question as to what exact power it confers. The words of the section convey no picture of what is intended or what is legally authorized. On its face the provision seems innocuous, a sensible form of words that attracts deference to some reasonable, pre-planned administrative arrangements. But the devil is in the details. Arguably what the provision really provides, through the opaque technique of incorporation by reference, is a series of blank cheques which authorize public officials to do anything they see fit so long as it is written down in some plan. The plans referred to in this provision contain:

- procedures to be taken for safety or evacuation;
- procedures to obtain and distribute materials, equipment, and supplies ;
- any other matter required by emergency plan standards under s. 14;[460]
- such other matters as are considered necessary or advisable for the implementation of the emergency plan during an emergency.

It does not stretch the imagination to envisage the wide fields of power opened up by this provision. Arrest, confiscation, conscription, forced medical treatment, indeed any power

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> (c) in the case of a municipality, designate one or more members of council who may exercise the powers and perform the duties of the head of council under this Act or the emergency plan during the absence of the head of council or during his or her inability to act;
>
> (d) establish committees and designate employees to be responsible for reviewing the emergency plan, training employees in their functions and implementing the emergency plan during an emergency;
>
> (e) provide for obtaining and distributing materials, equipment and supplies during an emergency;
>
> (e.1) provide for any other matter required by the standards for emergency plans set under section 14; and
>
> (f) provide for such other matters as are considered necessary or advisable for the implementation of the emergency plan during an emergency. R.S.O. 1990, c. E.9, s. 9; 2002, c. 14, s. 13.

[460] Section 14 provides a blank cheque within a blank cheque. It provides that "The Solicitor General may make regulations setting standards for the development and implementation of emergency management programs under sections 2.1 and 5.1 and for the formulation and implementation of emergency plans under sections 3 and 6." This represents a further delegation of power to the Minister of Public Safety to write into emergency plans whatever powers he may see fit from time to time, without limitation.

imaginable could be written into any of these plans with the stroke of a pen. This would enable public officials to exercise any power they wished so long as they wrote it down beforehand.

It is at first sight difficult to see why such a power is necessary or appropriate in an emergency powers statute. It adds a wild card to the entire list of enumerated powers that follow it in s. 7.0.2(4) of Bill 138. Through the technique of incorporation by reference it delegates a limitless range of unspecified powers to government officials. It lacks transparency.

It may be that this provision is an historical artifact that harkens back to the Premier's power under the *Emergency Management Act* to implement emergency plans. That section, which would be repealed under the new emergency statute, provides:

> 7. (1) The Premier of Ontario may declare that an emergency exists throughout Ontario or in any part thereof and may take such action and make such orders as he or she considers necessary and are **not contrary to law** to implement the emergency plans formulated under section 6 or 8 and to protect property and the health, safety and welfare of the inhabitants of the emergency area. R.S.O. 1990, c. E.9, s. 7 (1). [emphasis added]

Absent from the proposed power to implement emergency plans is the safeguard that restricts emergency response to actions that are not contrary to any existing law. The omission of this safeguard exacerbates the blank cheque nature of proposed s. 7.0.2(4)1. That said, even if this safeguard were restored by an amendment to the power in s. 7.0.2(4)1 to implement emergency plans, the lack of transparency would remain.

Recommendations

The Commission therefore recommends that:

- **The power to implement emergency plans be amended to ensure that it confers no powers other than those explicitly set out in Bill 138.**
- **Bill 138 be amended to provide that every emergency plan requires protocols for safe and speedy court access developed in consultation with the judiciary, and that the Courts of Justice Act be amended to ensure an early hearing for any proceeding under or in respect of emergency legislation or any action taken under it.**
- **The Attorney General's Department scrutinize Bill 138 intensely for transparency to ensure that it confers no hidden powers and that all powers conferred are clearly set out on the face of the statute.**

Bill 138: Basket Clause

At the end of its list of emergency powers, Bill 138 provides a "basket clause" to catch and include any power similar to those expressly provided, that may prove necessary:

> 7.0.2 (3), the Lieutenant Governor in Council may make orders in respect of the following:
>
> ...
>
> 12. Consistent with the powers authorized in this subsection, the taking of such other actions or implementing such other measures as the Lieutenant Governor in Council considers necessary in order to prevent, respond to or alleviate the effects of the emergency.

Most emergency statutes contain such a clause. In some cases it is appended as an introduction to the list of conferred powers.[461] For example, s.10(1) of British Columbia's *Emergency Program Act* begins by providing that after a declaration of emergency,

> … the minister may do all acts and implement all procedures that the minister considers necessary to prevent, respond to or alleviate the effects of an emergency or a disaster, including any or all of the following….

In other cases it appears at the end of the list as free-standing power. For example, s. 18(1) of Saskatchewan's *Emergency Planning Act*[462] sets out a list of powers to be exercised by the Minister in the event of a declaration of emergency. The last of these is as follows:

> … do all acts and take all proceedings that are reasonably necessary to meet the emergency.

Bill 138 uses an approach similar to that followed in the Saskatchewan legislation but with one crucial difference, Bill 138 does not impose any reasonableness standard. Indeed the requirement of reasonable grounds is strikingly absent from Bill 138 as a whole. It is true, as has been noted, that the power to make emergency orders is conferred by s. 7.0.2(2)[463] is made conditional on the requirement that the decision-maker must first determine that there is no "reasonable alternative" to the order. However, it is suggested that this is an inadequate alternative. As noted in the section on "Trigger, Criteria and Limitations," not only does it require inordinate powers of prescience, but it also represents an unusual departure from the ordinary language of "reasonable grounds" or "reasonable apprehension" that is so familiar and well-tested in our law.

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[461] R.S.B.C. 1996, c. 111.

[462] S.S. 1989-90, c. E-8.1.

[463] Criteria for emergency orders

> 7.0.2(2) If an emergency is declared under section 7.0.1, the Lieutenant Governor in Council may make such orders as the Lieutenant Governor in Council considers necessary and essential in the circumstances to prevent, reduce or mitigate serious harm to persons or substantial damage to property,
>
> (a) if the harm or damage will be alleviated by the order; and
>
> (b) if there is no reasonable alternative to the order.

Recommendation

The Commission therefore recommends that:

- **The basket clause s. 7.0.2(4)12 be reviewed on the same basis as that recommended above for the trigger and criteria and limitations, the basis of reasonable apprehension.**

Bill 138: Occupational Health and Safety

Bill 138 exempts occupational health and safety laws from the override power. The emergency powers trump every Ontario law except health and safety laws:

> 7.0.6 (1) In the event of a conflict between an order made under section 7.0.2 and any statute, regulation, rule, by-law or order, the order under section 7.0.2 prevails.
>
> ...
>
> Preservation of duties and rights
>
> (4) Despite subsection (1), nothing in this Act or in an order made under it abrogates any duties that are imposed and rights that are provided under the *Occupational Health and Safety Act.*

The discussion draft statute from the Attorney General's Department did not contain this provision that preserves every occupational health and safety regulation from the force of every emergency order. The exemption was added by the Justice Policy Committee when it drafted Bill 138. The Justice Policy Committee had heard strong arguments that safety regulations should remain in force during an emergency and should not be overriden by emergency orders.

Marcelle Goldenberg, a lawyer with the Service Employees International Union, told the Justice Policy Committee:

> Until the Ontario government can guarantee the health and safety of workers, it cannot force them to perform emergency work of an unknown nature. SEIU believes the province should not legislate a statutory provision empowering the Lieutenant Governor to direct any person or member of a

> class of persons to render services of a type that the person may reasonably be qualified to perform in emergency situations.[464]
>
> ---
>
> Until health care workers are assured that they will receive the proper training and personal protective equipment for the infectious diseases they must encounter, they cannot be ordered by any authority to put their lives on the line.[465]

Risa Pancer, a lawyer with the Canadian Union of Public Employees, told the Justice Policy Committee:

> We are also, though, putting in it how we're going to deal with occupational health and safety concerns, that the act will apply and everyone will have the right to raise concerns during an emergency and feel no fear of retaliation.[466]

Leah Casselman, president of the Ontario Public Services Employees Union, referred in her testimony to recommendations her union has made to the Commission on,

- the need to protect employees' rights and collective agreements during emergencies.
- avoiding the circumvention of employers' occupational health and safety obligations.[467]

These powerful arguments reflect the concerns of front line health care workers who were exposed to risk during SARS. They lack confidence in existing occupational and health safeguards. They lack confidence in the operation of the machinery of enforcement in place during SARS. In light of these concerns they cannot accept any legislative measure that appears to erode whatever safety protection they now have, inadequate though it may be.

These concerns, as noted above, are a major part of the Commission's ongoing investigation and will be addressed in the Commission's final report. It is enough to say at this time that nothing in the evidence examined so far suggests to the Commission that it would be wise to enact a complete emergency override of occupational health and safety laws.

The health and safety of emergency workers is a fundamental element of every emergency response. One of the strongest lessons from SARS is that the health and safety of health care workers and other first responders is paramount in a public health emergency. SARS demonstrated that emergency response can be seriously hampered by high levels of illness or quarantine among health care workers. As Dr. Young has said:

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[464] Justice Policy Committee, Public Hearings, October 14, 2004, p. 360.

[465] *Ibid*, p. 361.

[466] Justice Policy Committee, October 14, 2004, p. 364.

[467] *Ibid*, p. 356.

> Certainly one of my priorities is occupational health and safety of the first responders, whether they are hospital workers or whether they're fire or police, or farm workers in the case of avian flu.[468]

Those who favour a limited override of some safety regulations point out that they may contain minor technical provisions that do not directly protect workers, provisions that might be overridden in an emergency without affecting worker safety.

If such provisions exist, and if they would unreasonably impair emergency response, and if it would not endanger workers to override these provisions, the burden of persuasion is on those who would argue that some safety provisions may be safely overridden.

The solution, to any concern that occupational health and safety laws might impede emergency response, is not to enact a blunt override of those laws. Emergency orders will not work if they leave workers deep concern for their personal health and safety. The deepest concern of workers in an infectious outbreak is not their own safety but the safety of their families and those they may infect if not properly protected.

Emergency orders that do not meet these concerns cannot be enforced.

To override occupational health and safety laws would eliminate even the restricted rights of first-responders to refuse unsafe work at a time when other protective measures might also be weakened. In such a hazardous environment, such a draconian measure would be impossible to enforce. Health care workers and other front-line responders may decide in future emergencies, as so many did so heroically during SARS, to accept heightened levels of personal risk voluntarily. But no one, no matter how dedicated and conscientious, should or can be legally coerced to work in an unsafe work environment that they believe will harm themselves and their families. And as a practical matter such legal coercion would be impossible to enforce.

Doris Grinspun, executive director of the Registered Nurses Association of Ontario, has stated:

> … you cannot really mandate people to work. Yes, you can put the legislation, all right, but people can call and say, "I am sick" – one way or another … When some refused [during SARS], they were afraid of the protection. So, again, let's be prepared for how we protect not only our nurses but doctors and others, and we will have fewer and fewer refusals.[469]

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[468] Justice Policy Committee, Public Hearings, August 3, 2004, p. 17.

[469] Justice Policy Committee, Public Hearings, August 26, 2004, p. 272.

The Justice Policy Committee, in its *Report on the Review of Emergency Management Law in Ontario*, stated:

> Emergencies put special stress on workers and employers where work is temporarily interrupted, or otherwise affected by the emergency. In a declared emergency under the *Emergency Management Act* it is necessary to ensure that help is available, while at the same time acknowledging (i) statutory and contractual employment, labour, and occupational health and safety standards, and (ii) issues under the *Human Rights Code*.
>
>> 12. The Committee recommends that the government seek to facilitate the development of protocols under which management and employees can deal with the extraordinary circumstance of an emergency.
>>
>> 13. The Committee recommends that the government review labour and employment legislation with a view to ensuring that the tools needed to respond adequately to a provincial emergency are available.[470]

The Commission agrees that it is important to have mechanisms in place to deal with any health and safety workplace issues that may arise during a future public health emergency in order to:

- Prevent situations from developing that would leave health care and other front-line workers with no choice but to seriously consider refusing work; and
- Develop effective means for workplace parties to work out thorny issues that might arise during an emergency.

These points were made by both management and labour.

Janet Beed, the chief operating officer of the Ontario Hospital Association, has stated:

> Labour issues will always be contentious, but if you have a health crisis, labour issues need to have been considered long before the crisis occurs. You can appreciate that there are many issues. What we learned from SARS is that what is needed is a process to bring together the various partners – union, management, government, ministries, associations – to address these very complex systemic and legal issues, but we need to do that long before the crisis hits. When the crisis hits, we need timely action; we don't need bringing a group together that hasn't worked together before or has only

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[470] Justice Policy Committee, *Report on the Review of Emergency Management Law in Ontario* (Toronto: November 1, 2004), p. 13.

> worked in distant relationships. Bringing that group together in anticipation and setting up a set of ideologies and legislative requirements will help.[471]

One union in a written submission to the Commission, recommended:

> 1. The Public Hospitals Act should be amended to provide that each hospital should have in place a health emergency plan in advance of any emergency. Where the hospital is unionized, the health emergency plans should be negotiated with unions through collective bargaining to address issues affecting the employment conditions of health care workers. Issues to be bargained and included in the health emergency plan should include:
>
> > a. deployment of staff during an emergency;
> >
> > b. scheduling and hours of work for health care workers during an emergency;
> >
> > c. pay for health care workers during an emergency, including any entitlement to emergency premiums and protection from financial disadvantage caused by the emergency;
> >
> > d. plans for staffing an emergency, including whether staffing should occur on a voluntary basis and whether those who volunteer should be entitled to premium pay;
> >
> > e. training health care workers for the implementation of emergency plans, both in advance of any emergency and during the emergency;
> >
> > f. training health care workers for additional health and safety issues arising during an emergency;
> >
> > g. management of health care worker stress during an emergency;
> >
> > h. protection of occupational health and safety standards during an emergency;
> >
> > i. impact of restrictions on health care worker employment during an emergency (e.g. restrictions placed on those who work in more than one facility);
> >
> > j. impact on health care workers caused by the shut-down of facilities, including in terms of compensation;
> >
> > k. workers requiring particular accommodation during an emergency, for example, pregnant workers or immunosuppressed workers;

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[471] Justice Policy Committee, Public Hearings, August 18, 2004, p. 147.

> l. workers required to be placed in quarantine during an emergency;
>
> m. long-term impact on health care workers caused by the emergency; and
>
> n. vacation entitlement during an emergency.
>
> Some of the above issues, such as those dealing with compensation, should be bargained between central parties, while other issues, for example scheduling and hours of work, should be bargained locally according to principles determined by the central parties.

Another union in a submission to the Commission said this:

> … early in SARS, an ad hoc committee to address issues arising out of SARS workplaces was established by the MOHLTC. It was comprised of representatives of the MOHLTC, the Ministry of Labour, the Workplace Safety and Insurance Board (WSIB), the OHA, various affected hospitals and most of the health-care unions, including [the union] …
>
> The committee met once or twice a week, either in person or by teleconference, between April 1, and June 2003. It discussed such issues as staffing, health and safety, movement of staff between facilities and compensation. The committee did have serious limitations. It did not know about, or approve, the enhancements given to staff by hospitals. In addition, it did not solve many of the communication problems that existed during SARS. [Union] representatives were frustrated that many of their questions were not answered and that crucial information was not available to them, in spite of committee meetings.
>
> However, on the positive side, the committee did discuss and approve creative staffing solutions to the SARS crisis. For instance, rather than enhancing pay, it concluded that it was preferable to shorten working hours for nurses working in SARS units with no reduction in pay. In addition, the committee worked out the details of a government initiated Compassionate Assistance Program that provided compensation to nurses who suffered financial loss due to the impact of SARS …
>
> During a health emergency a provincial ad hoc committee, similar to the one operating during SARS, should be struck to deal with ongoing issues. The committee should include representation from all unions with affected members. Each hospital should also strike an ad hoc committee that has union representation. This committee should also include representation from the public health sector to facilitate the integration and coordination of response between hospitals and public health services.

As noted above it is the position of the Commission that the onus is on those who favor the power to suspend occupational health and safety protections during an emergency to prove their case. Thus far, they have not done so. What is needed during an emergency, instead of a blunt override of occupational health and safety protections, is a pre-planned, pre-existing process to sort out quickly any workplace issues that touch on occupational health and safety.

Recommendation

The Commission therefore recommends that:

- **Every emergency plan provide for a process to facilitate advance planning to address potential workplace health and safety issues and to work out those issues when they arise.**

Bill 138: The Problem of Concurrent Powers

It is important to ensure that Bill 138, in conferring new emergency powers, does not take away any existing powers that might be used in an emergency such as the powers in the *Health Protection and Promotion Act*, the *Police Services Act* and other Ontario statutes, and ancillary and inherent powers such as those used to evacuate 218,000 Mississauga residents after the 1979 chlorine gas train derailment.

The Commission recommends that Bill 138 explicitly provide that it does not derogate from any of these existing powers that might be used in an emergency.

The continuing existence of these separate and concurrent streams of power should not become a trap for the emergency responder faced with a choice of powers to accomplish the same end. What is needed is a way to prevent the two different streams of authority from forcing an emergency responder, who must act in a hurry, to stop and wait for lawyers to debate which power is more appropriate. So long as the emergency response is justified by law it should not matter which overlapping stream of authority was chosen.

For instance the existence of concurrent powers under the *Health Protection and Promotion Act* and Bill 138 may create uncertainty about the preferable choice of power and may force emergency responders to ponder which power to use. If I use the wrong power, will my action be invalid? Will I suffer consequences? Do I use the *Health Protection and Promotion Act's* s. 87 to seize the motel as a temporary isolation facility, or do I use the powers in Bill 138 (assuming they have been amended to make them compulsory)? What are the legal consequences of each choice? These are questions that emergency responders should not have to ask themselves.

The responder should not have to scratch his head and take legal advice as to the precise differences between these overlapping powers. So long as the action is authorized by one statute or the other, the responder should be able to go ahead with confidence and just do it. And the responder should be able to avoid legal challenges based on legalistic pigeonholes. Emergency responders should not have to spend hours under cross examination in a later court challenge answering questions like: Did you do it under the *Health Protection and Promotion Act*? If so, did you dot this i and cross this t? Did you do it under Bill 138? If so, did you dot these other i's and cross these other t's? The way to avoid these problems down the line is to provide that the emergency action is valid so long as it is authorized by law, no matter which legal pigeonhole it might best fit.

Recommendations

The Commission therefore recommends that:

- **Bill 138 be amended to provide:**
    - **That Bill 138 does not derogate from the powers authorized by any Ontario Statute or any ancillary or inherent authority;**
    - **That no order made or action purportedly taken under Bill 138 shall be set aside on grounds it is not authorized by the Act if the order or action is authorized by some other Ontario statute or inherent or ancillary power; and**
    - **That no order made or action taken in response to a declared emergency under the purported authority of any Ontario statute or inherent or ancillary power shall be set aside for lack of legal authority if the order or action is authorized under Bill 138.**

Conclusion and Summary of Recommendations

For the reasons above, the Commission recommends that:

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

- **Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.**

- **Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2(4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.**

- **All powers proposed in Bill 138 be examined to remove ambiguity of the sort that appears in s. 7.0.2(4) 7, 8 and 9 to ensure there is no** lack of clarity as to the intended purpose and legal effect of any proposed power.

- For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act* health protection powers.

- Emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:

    - Public health emergency planning;

    - Public communication of health risk, necessary precautions, regular situation updates;

    - Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;

    - Strategic advice to the government in the management of the emergency;

    - Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;

    - Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;

    - Delegated authority in respect of emergency orders of a public health nature; and

    - Such further and other authority, of a nature consistent with the authority referred to above, in respect of the public health aspects of any emergency.

- Emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency

Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.

- **Bill 138 be subjected to a fundamental legal and constitutional overhaul by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.**

- **The government in its review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to above.**

- **The power of mass compulsory immunization not be enacted as a permanent feature of Ontario's law until the evidence has been presented in a comprehensive fashion.**

- **Every proposed emergency power, before its enactment, be thoroughly subjected to the legal, practical, and policy analysis exemplified by the above analysis of compulsory mass immunization and that the evidence in support of each power be presented in a comprehensive fashion before enactment.**

- **If the government decides it is necessary to enact any emergency power before there is time to subject it thoroughly to the legal, practical, and policy analysis exemplified by this analysis of compulsory mass immunization, that the government sunset any such provision for a period not to exceed two years in order to provide time for the required scrutiny.**

- **The Attorney General in the review of Bill 138 clarify whether the override power in s. 7.0.6(1) affects collective agreements.**

- **The Attorney General undertake a thorough scrutiny and amendment of the override provision to protect our foundational legal statutes such as the *Habeas Corpus Act,*[472] the *Legislative Assembly Act,*[473] the *Human Rights Code,*[474] the *Elections Act,*[475] and the *Courts of Justice Act*[476] against emergency override.**

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[472] R.S.O. 1990, c. H-1.

[473] R.S.O. 1990, c. L-10.

- **It be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.**

- **The override power be given a more prominent place in the statute by putting it right after the enumerated powers.**

- **The Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.**[477]

- **The structure and content of the limitations and criteria for the declaration of emergency and the exercise of emergency powers be reviewed with a view to the development of a standard based on the decision-maker's reasonable apprehension that the exercise of the power is necessary in the circumstances;.**

- **The power to implement emergency plans be amended to ensure that it confers no powers other than those explicitly set out in Bill 138.**

- **Bill 138 be amended to provide that every emergency plan requires protocols for safe and speedy court access developed in consultation with the judiciary, and that the Courts of Justice Act be amended to ensure an early hearing for any proceeding under or in respect of emergency legislation or any action taken under it.**

- **The Attorney General's Department scrutinize Bill 138 intensely for transparency to ensure that it confers no hidden powers and that all powers conferred are clearly set out on the face of the statute.**

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[474] R.S.O. 1990, c. H-19.

[475] R.S.O. 1990, c. E-6.

[476] R.S.O. 1990, c. C-43.

[477] For vagueness, see for instance Gonthier J. in *R. v. Nova Scotia Pharmaceutical Society* [1992] 2 S.C.R. 606 at para 69. For delegation of plenary discretion, see for instance *Irwin Toy Ltd. v. Quebec (A.G.)* [1989] 1 S.C.R. 927 at para 63.

- The basket clause s. 7.0.2(4)12 be reviewed on the same basis as that recommended above for the trigger and criteria and limitations, the basis of reasonable apprehension.

- Every emergency plan provide for a process to facilitate advance planning to address potential workplace health and safety issues and to work out those issues when they arise.

- Bill 138 be amended to provide:
    - That Bill 138 does not derogate from the powers authorized by any Ontario Statute or any ancillary or inherent authority.
    - That no order made or action purportedly taken under Bill 138 shall be set aside on grounds it is not authorized by the Act if the order or action is authorized by some other Ontario statute or inherent or ancillary power.
    - That no order made or action taken in response to a declared emergency under the purported authority of any Ontario statute or inherent or ancillary power shall be set aside for lack of legal authority if the order or action is authorized under Bill 138.

12. Conclusion and Summary of Recommendations

For the reasons above, noted in the executive summary, the Commission recommends[478] that:

MEDICAL INDEPENDENCE AND LEADERSHIP

- **The *Health Protection and Promotion Act* be amended to transfer the powers in ss. 82 through 85 (power over assessors) to the Chief Medical Officer of Health.**
- **The Minister's power under s. 79 of the *Health Protection and Promotion Act*, to establish and direct public health laboratory centres be transferred from the Minister to the Chief Medical Officer of Health, until such time as the establishment of the Ontario Health Protection and Promotion Agency and the transfer of power over the laboratories in accordance with the recommendations of the Walker Report.**
- **The *Health Protection and Promotion Act* be amended to transfer the power in s. 102(2) (enforcement powers) to the Chief Medical Officer of Health.**
- **The *Health Protection and Promotion Act* be amended to remove from s. 102(1) the Minister as a listed person who may exercise that power.**
- **The *Health Protection and Promotion Act* be amended to transfer the powers in s. 80 (power over inspectors) to the Chief Medical Officer of Health.**
- **The powers in s. 78 (appointment of inquiry) and in s. 87 (commandeering buildings for use as temporary isolation facilities) remain as they are, to be exercised by the Minister of Health and Long-Term Care.**
- **The *Health Protection and Promotion Act* be amended to provide for every local medical officer of health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:**

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[478] The Commission's recommendations, if accepted, will have to be put into statutory language by Legislative Counsel, an officer of the Legislative Assembly, with the assistance of departmental lawyers. Although the recommendations sometimes use statutory language they are not offered as statutory amendments but only as a basis for the drafting language chosen by Legislative Counsel to achieve their intent and purpose.

○ Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health:

    - **To report every year publicly on the state of public health in the unit. This report must be provided to the local board of health and the Chief Medical Officer of Health 30 days prior to it being made public; and**

    - **To make any other reports respecting the public's health as he or she considers appropriate, and to present such a report to the public or any other person, at any time he or she considers appropriate.**

○ Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any medical officer of health in respect of the good faith exercise of those reporting powers and duties.

- **The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health.**

- **These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.**

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health under the *Health Protection and Promotion Act.***

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication under the direction of the local medical officer of health be added to the list of mandatory public health programmes and services required by s. 5 of the *Health Protection and Promotion Act.***

- **The Emergency Management Unit of the Ministry of Health and Long-Term Care be moved to the Public Health Division with its Director reporting directly to the Chief Medical Officer of Health.**

- **The *Health Protection and Promotion Act* be amended to require that each local board of health and each medical officer of health provide to the Chief Medical Officer of Health a copy of their general public health emergency plan and any incident specific**

plans and ensure that the Chief Medical Officer of Health has, at any time, the most current version of those plans.

- **Section 95 (protection from personal liability) of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.**

LOCAL GOVERNANCE

- **The province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review, decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 per cent to the province.**

- **The Ministry of Health and Long-Term Care enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health. In particular, the Ministry of Health and Long-Term Care should:**
    - **Amend and strengthen s. 67 of the *Health Protection and Promotion Act* to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials;**
    - **Take enforcement actions in respect of violations of s. 67;**
    - **Amend the *Health Protection and Promotion Act* to clearly state that the medical officer of health is the chief executive officer of the board of health; and**
    - **Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence parallel to that of the Chief Medical Officer of Health, as set out in Chapter 1 of this Report.**

- **Section 7 of the *Health Protection and Promotion Act* be amended to provide that the Minister, on the advice of the Chief Medical**

Officer of Health shall publish standards for the provision of mandatory health programmes and services, and every board of health shall comply with the published standards that shall have the force of regulations.

- **The *Health Protection and Promotion Act* be amended to require by law the regular monitoring and auditing, including random spot auditing, of local health units to ensure compliance with provincial standards. The results of any such audits should be made public so citizens can keep abreast of the level of performance of their local health unit.**

- **The *Health Protection and Promotion Act* be amended to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health. In particular, the Ministry of Health and Long-Term Care should:**

    - **appoint a majority of the members of each local board, to reflect the greater proportion of provincial public health funding and influence;**

    - **amend the *Health Protection and Promotion Act* to provide that where cabinet has not by Order in Council, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health;**

    - **amend the *Health Protection and Promotion Act* to require that those appointed to boards of health possess a demonstrated experience or interest in the goals of public health – to prevent the spread of disease and protect the health of the people of Ontario – and that they be broadly representative of the community to be served; and**

    - **consider an amendment to the *Health Protection and Promotion Act* to clarify the roles and priorities of health board members, the first priority being compliance with the *Health Protection and Promotion Act* and the mandatory public health standards.**

- **The Ministry of Health and Long-Term Care introduce a package of governance standards for local boards of health with reference to those sources referred to above, such as the Scott and Quigley governance framework.**

HPPA TUNEUP

- **The four present categories of disease: infectious, communicable, reportable, and virulent, be simplified and reduced to two categories with clear boundaries and clear legal consequences.**

- **The *Health Protection and Promotion Act* be amended to clarify whether the powers contained in the various parts of the Act apply outside of the Part of the Act in which the power is contained. For example, does s. 13 apply in the case of a communicable disease?**

- **The Ministry of Health and Long-Term Care consider whether the definition of "health hazard" needs to be updated or expanded.**

- **The Ministry of Health and Long-Term Care review the numerous standards of intervention contained in the Act, examples of which are noted above, with a view to amending the Act to simplify and rationalize the apparently haphazard and overlapping standards for intervention, and to ensure that whether there is a hard trigger or a soft trigger, it should be rationally connected to the power being wielded.**

- **Section 22 of the *Health Protection and Promotion Act* be amended to adjust the standard of intervention to provide that the medical officer of health can take necessary action without the criminal or quasi-criminal standard of objective proof on reasonable and probable grounds.**

- **The Ministry of Health and Long-Term Care, in consultation with the public health community, examine the issue of any practical difficulties of administering s. 22, with a view to make it more effective for those who rely on its powers.**

- **The *Health Protection and Promotion Act* be amended to provide that an order made under s. 22, in respect of a person infected with a communicable disease, is valid in any health unit in Ontario.**

STRONGER HEALTH PROTECTION POWERS

- **The role and authority of public health officials in relation to hospitals be clearly defined in the *Health Protection and Promotion Act* in accordance with the following principles:**

  - **The requirement that each public health unit have a presence in hospital infection control committees should be entrenched in the Act; and**

  - **The authority of the local medical officers of health and the Chief Medical Officer of Health in relation to institutional infectious disease surveillance and control should be enacted to include, without being limited to, the power to monitor, advise, investigate, require investigation by the hospital or an independent investigator, and intervene where necessary.**

- **The Ministry of Health and Long-Term Care, in consultation with the Provincial Infectious Diseases Advisory Committee, and the wider health care and public health communities, define a broad reporting trigger that would require reporting to public health where there is an infection control problem or an unexplained illness or cluster of illness.**

- **Whether or not a workable trigger can be defined for compulsory reporting, a provision be added to the *Health Protection and Promotion Act*, to provide that a physician, infection control practitioner or hospital administrator may voluntarily report to public health officials the presence of any threat to the health of the population.**

- **The *Health Protection and Promotion Act* be amended to include powers similar to those set out in Quebec's *Public Health Act*, to allow for early intervention and investigation of situations, not limited to reportable or communicable diseases, that may pose a threat to the health of the public.**

- **The *Health Protection and Promotion Act* be amended to clarify and regularize in a transparent system authorized by law, the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding how a particular case should be classified.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to issue directives to hospitals, medical clinics, long-term care facilities, and all other health care providers, private or public, in respect of precautions and procedures necessary to protect the public's health. All directives should be issued under the signature of the Chief Medical Officer of Health alone.**

- **The Ministry of Health and Long-Term Care appoint a working group of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by** the directives knows how they work, what they mean and how they should be applied.

- The Ministry of Health and Long-Term Care, in consultation with the affected health care communities, develop feedback machinery driven by health care workers in the field, to ensure the directives are clear and manageable from a practical point of view in the field.

- The *Health Protection and Promotion Act* and the directives provide explicitly that they in no way diminish the procedures and precautions required by the circumstances that prevail in any particular institution, that they represent the floor, not the ceiling, of medical precaution, and do not relieve any institution of the obligation to take further precautions where medically indicated.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order temporarily detained for identification any person who refuses to provide their name, address and telephone contact information when required to do so for the purpose of identifying those who are leaving, or have been in a place of infection. The detained person unless immediately released, must be brought before a justice as soon as possible and in any event within 24 hours for a court hearing. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of, for the purpose of a court hearing, any person suspected of having been exposed to a health hazard, and who refuses to consent to decontamination. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of anyone who there is reason to suspect is infected with an agent of a virulent disease, for the purposes of obtaining a judicial order authorizing the isolation, examination or treatment of the person, pursuant to s. 35 of the *Health Protection and Promotion Act.* The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

- The *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a private dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.

- The *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling-house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.

REPORTING INFECTIOUS DISEASE

- The *Health Protection and Promotion Act* be amended to repeal, in the duty of a physician to report to the medical officer of health, the distinction between hospital patients and non-hospital patients. This may be achieved by deleting from s. 25(1) the words "who is not a patient in or an out-patient of a hospital."

- The Ministry of Health and Long-Term Care require each hospital, long-term care facility, nursing home, home for the aged, community care access centre, private medical or health services clinic, and any health care institution, to establish an internal system to ensure compliance with the reporting obligations set out in the *Health Protection and Promotion Act.*

- The definition of "practitioner" in the *Health Protection and Promotion Act* be amended to coincide with that set out in the *Personal Health Information Protection Act.*

- The list of "institutions" as defined in s. 21(1) of the *Health Protection and Promotion Act,* be amended to coincide with that set out in the *Personal Health Information Protection Act.*

- The *Health Protection and Promotion Act* be amended to ensure consistency between those who are defined as "health information custodians" under the *Personal Health Information Protection Act*

and those who have reporting obligations under the *Health Protection and Promotion Act*.

- **The *Health Protection and Promotion Act* be amended to authorize the Minister of Health and Long-Term Care to amend the definition of "practitioner" or "institution" by regulation.**

- **The *Health Protection and Promotion Act* be amended to include a provision similar to the provisions in Quebec's *Public Health Act*, by which the Quebec public health director may order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential.**

- **This power should be broadly defined, to enable the Chief Medical Officer of Health to require any person, organization, institution, government department or other entity, to provide information, including personal health information, to the Chief Medical Officer of Health, for the purposes of investigating and preventing the spread of infectious disease.[479]**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to order the collection, analysis and retention of any laboratory specimen from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analysis from anyone, and to disclose the results of test analysis as the Chief Medical Officer of Health considers appropriate for the purpose of investigating and preventing the spread of infectious disease.[480] This power, however, should be subject to the following restrictions:**

    - **It should not include the power to take a bodily sample or specimen directly from a person without their consent or, absent consent, without court order. The power should only apply to specimens already taken;**

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[479] As noted above, this is not drafting language. The use of the term "infectious disease" is intended to include but not be restricted to diseases already designated as communicable, reportable or virulent under the *Health Protection and Promotion Act*. The provision should be defined broadly enough to cover bioterrorism risks. It should not, however, extend to every health risk, such as obesity or other lifestyle problems.

[480] *Ibid.*

  - The collection should be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen should be used only for this express purpose; and
  - The power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.

- The *Health Protection and Promotion Act* be amended to require that in the case of specific diseases, designated by regulation, information be reported "immediately" by telephone to the local medical officer of health, and that such report be followed up in writing within 24 hours;
- The *Health Protection and Promotion Act* be amended to require that as in the case of those diseases not designated for immediate reporting, a written report must be provided to the local medical officer of health within 24 hours.
- Subsection 1(2) of Regulation 569 be expanded to apply to any person who makes a report under the *Health Protection and Promotion Act*. Thus any person who gives information in accordance with a duty under the *Health Protection and Promotion Act*, shall, upon the request of the medical officer of health, give to the medical officer of health such additional information respecting the reportable disease or communicable disease, as the medical officer of health considers necessary.
- This portion of Regulation 569 (s. 1(2), additional information) be moved to the Act itself, to form an integral part of the reporting obligations set out in the Act and to ensure that the power is protected, absent legislative debate, from subsequent amendment.
- Amendments to the *Health Protection and Promotion Act* and Regulations be preceded by consultation with the public health community who have to apply them in the field.
- Local public health officials and the Public Health Division, in collaboration and consultation with hospitals, other health care institutions and professional organizations, develop a standardized form and means for reporting under the *Health Protection and Promotion Act*.
- The standardized reporting include clarity around to whom the report must be made, and to clearly confirm that the chain of transmission goes from the hospital and health care facilities, to the local health units, to the province, so as to avoid multiple requests for information.

- **The Ministry of Health and Long-Term Care, Public Health Division, in collaboration with local medical officers of health, health care facilities and professional organizations, engage in broad-based education of reporting requirements under the *Health Protection and Promotion Act* and that such education be maintained on a regular basis.**

- **The *Health Protection and Promotion Act* be amended to require public health authorities to report to a hospital or any other health care facility, including family medical clinics, any information in the hands of public health that suggests a reportable disease may have been acquired through exposure at that site.**

- **Section 39(2) of the *Health Protection and Promotion Act* be amended to include an exception permitting public health officials to provide hospitals and other health care facilities, with the personal health information of persons about whom a report is made, where they are of the opinion that the information may reduce the risk of exposure or transmission to staff, patients or visitors.**

PRIVACY AND DISCLOSURE

- **Section 39 of the *Personal Health Information Protection Act* be amended to include:**
  - **A health information custodian shall disclose personal health information about an individual, to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act.***

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to any person where it is necessary to investigate or prevent the spread of a communicable disease.**

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to a public** health authority as described in s. 39(2)(b) of the *Personal Health Information Protection Act.*

- The *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from providing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act.*

- The *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to state that in the event of any conflict between the two statutes, the duties in the *Health Protection and Promotion Act* prevail.

- The *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act,* the health information custodian will be exempt from liability.

- The Ministry of Health and Long-Term Care, in consultation with the appropriate community, establish procedures for the fast-tracking of approval of access to personal health information for the purposes of urgently required research, to enable health care custodians to provide access to data in a timely manner, without fear of violating privacy legislation.

- The Chief Medical Officer of Health review, and if necessary strengthen, the internal protocols and procedures now in place to ensure effective privacy safeguards for personal health information received by public health authorities.

WHISTLEBLOWER PROTECTION

- The *Health Protection and Promotion Act* be amended to provide health care workers whistleblower protection in accordance with the following principles:

    - It applies to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;

    - It enables disclosure to a medical officer of health (including the Chief Medical Officer of Health);

  - **It includes disclosure to the medical officer of health (including the Chief Medical Officer of Health) of confidential personal health information;**
  - **It applies to the risk of spread of an infectious disease and to failures to conform to the *Health Protection and Promotion Act*;**
  - **It prohibits any form of reprisal, retaliation or adverse employment consequences direct or indirect;**[481]
  - **It requires only good faith on the part of the employee; and**
  - **It not only punishes the violating employer but also provides a remedy for the employee.**[482]

QUARANTINE

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**
- **The *Health Protection and Promotion Act* be amended to provide that it is a mandatory public health standard for each local medical officer of health to develop under the guidance of the Chief Medical Officer of Health a local plan in consultation with employers, educators, community groups, businesses, emergency responders, and health care facilities to ensure that plans are in place to ensure that those quarantined in the future have timely and adequate information, and the support necessary to encourage and enable them to comply with quarantine.**
- **The *Health Protection and Promotion Act* be amended to add a provision similar to s. 6(1) of the *SARS Assistance and Recovery Strategy Act*, to apply to infectious diseases as identified by the**

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[481] Although specific types of reprisal could be listed, as in Ontario's workplace legislation, the listing of specific examples can shift the focus from the strong general prohibition to any gaps in the examples that can be found by an ingenious lawyer or administrator. It is therefore recommended that the prohibition remain general.

[482] As noted above, the punishment recommended for an employer who violates the protection is a fine of up to $50,000.00 where the employer is a natural person and $250,000.00 where the employer is not a natural person.

Chief Medical Officer of Health. The amendment should provide, in respect of such a disease, that a person is entitled to a leave of absence without pay where he or she is unable to work as a result of investigation or treatment related to the disease, or because he or she is subject to quarantine or isolation.[483] The amendment should also protect those who are unable to work because they are needed to provide care or assistance to a spouse, child, grandparent, sibling or relative who is dependent on the employee for care and assistance.

- **Section 22(5.0.1) be amended to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.**

- **Section 106 of the *Health Protection and Promotion Act* be amended to provide that in the case of a class order made under s. 5.0.2, service is effective when notice of the class order is posted and the order may be enforced as soon as it is brought to the actual attention of the person affected.**

- **The word "quarantine" be introduced to the *Health Protection and Promotion Act* as a defined legal term to correspond to the universal popular understanding of that word as used during SARS.**

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[483] Section 6 (1) provides:

> During the period beginning March 26, 2003 and ending on a day specified by proclamation of the Lieutenant Governor under subsection 1(2), an employee is entitled to a leave of absence without pay for any day or part of a day during which he or she falls into one or more of the following categories:
>
> 1. The employee is unable to work because he or she is under individual medical investigation, supervision or treatment related to SARS.
>
> 2. The employee is unable to work because he or she is acting in accordance with a SARS related order under section 22 or 35 of the *Health Protection and Promotion Act*.
>
> 3. Subject to subsections (2) to (4), the employee is unable to work because he or she is in quarantine or isolation or is subject to a control measure in accordance with SARS related information or directions issued to the public, a part of the public or one or more individuals, by the Commissioner of Public Security, a public health official, a physician or a nurse or by Telehealth Ontario, the Government of Ontario, the Government of Canada, a municipal council or a board of health, whether through print, electronic, broadcast or other means.
>
> 4. The employee is unable to work because of a direction given by his or her employer in response to a concern of the employer that the employee may expose other individuals in the workplace to SARS.
>
> 5. The employee is unable to work because he or she is needed to provide care or assistance to an individual referred to in subsection (5) because of a SARS related matter that concerns that individual. 2003, c. 1, s. 6 (1).

LEGAL ACCESS AND PREPAREDNESS

- The *Health Protection and Promotion Act* be amended to eliminate the complex appeal process, rife with delay, in respect of an appeal by the subject of an order from a decision of the Health Services Appeal and Review Board, and provide an appeal as of right directly to the Court of Appeal with no prior requirement to secure leave to appeal.

- The Ministry of Health and Long-Term Care consider whether the Health Services Appeal and Review Board is a necessary step in the complex hearing and review process in the *Health Protection and Promotion Act* or whether some other system should be enacted.

- The *Health Protection and Promotion Act* be amended to simplify the complex and restrictive appeal process in respect of appeals from provincial court to the Superior Court and then to the Court of Appeal but only if a judge of the Court of Appeal grants leave to appeal on special grounds on a question of law alone. This process could be simplified by eliminating the intermediate appeal to the Superior court and the restricted leave to appeal to the Court of Appeal or both.

- The multiplicity of procedures in respect of the enforcement of Orders made under Part IV (communicable diseases) and Part VII (administration) of the *Health Protection and Promotion Act*, be replaced by a single, simple, codified procedure in the Superior Court.

- The *Health Protection and Promotion Act* be amended to provide the Superior Court, when ordering compliance with a public health obligation, with a full range of remedial power, including the power to make mandatory orders.

- The *Health Protection and Promotion Act* be amended to consolidate and codify all provisions in respect of court enforcement and access to judicial remedies in respect of communicable diseases into one seamless system or powers and procedures.

- The *Health Protection and Promotion Act* be amended to include special procedures such as *ex parte* procedures for interim and temporary orders, video and audio hearings, and other measures to prevent the court process from becoming a vector of infection.

- **The *Rules of Civil Procedure* be amended to include a clear, self-contained and complete code of procedure for public health enforcement and remedies in respect of communicable diseases.**

- **A consequential amendment to the *Courts of Justice Act* provide that proceedings in respect of the *Health Protection and Promotion Act* enforcement and remedies in respect of communicable diseases shall be heard at the earliest opportunity.**

- **The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found, and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.**

- **The judiciary be asked to establish court access protocols in consultation with the public health legal community.**

- **The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be fond, and the police service shall to all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.**

- **The Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General, together with public health officials, establish protocols and plans for the enforcement of orders under the *Health Protection and Promotion Act* and the involvement of police officers in that process.**

- **Legal preparedness be an integral component of all public health emergency plans.**

EMERGENCY LEGISLATION

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

- **Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.**

- **Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2(4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.**

- **All powers proposed in Bill 138 be examined to remove ambiguity of the sort that appears in s. 7.0.2(4) 7, 8 and 9 to ensure there is no lack of clarity as to the intended purpose and legal effect of any proposed power.**

- **For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act* health protection powers.**

- **Emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:**
    - **Public health emergency planning;**
    - **Public communication of health risk, necessary precautions, regular situation updates;**
    - **Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;**
    - **Strategic advice to the government in the management of the emergency;**
    - **Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;**
    - **Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;**
    - **Delegated authority in respect of emergency orders of a public health nature; and**

  - **Such further and other authority, of a nature consistent with the authority referred to above, in respect of the public health aspects of any emergency.**

- **Emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.**

- **Bill 138 be subjected to a fundamental legal and constitutional overhaul by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.**

- **The government in its review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to above.**

- **The power of mass compulsory immunization not be enacted as a permanent feature of Ontario's law until the evidence has been presented in a comprehensive fashion.**

- **Every proposed emergency power, before its enactment, be thoroughly subjected to the legal, practical, and policy analysis exemplified by the above analysis of compulsory mass immunization and that the evidence in support of each power be presented in a comprehensive fashion before enactment.**

- **If the government decides it is necessary to enact any emergency power before there is time to subject it thoroughly to the legal, practical, and policy analysis exemplified by this analysis of compulsory mass immunization, that the government sunset any such provision for a period not to exceed two years in order to provide time for the required scrutiny.**

- **The Attorney General in the review of Bill 138 clarify whether the override power in s. 7.0.6(1) affects collective agreements.**

- **The Attorney General undertake a thorough scrutiny and amendment of the override provision to protect our foundational**

legal statutes such as the *Habeas Corpus Act,*[484] the *Legislative Assembly Act,*[485] the *Human Rights Code,*[486] the *Elections Act,*[487] and the *Courts of Justice Act*[488] against emergency override.

- **It be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.**
- **The override power be given a more prominent place in the statute by putting it right after the enumerated powers.**
- **The Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.[489]**
- **The structure and content of the limitations and criteria for the declaration of emergency and the exercise of emergency powers be reviewed with a view to the development of a standard based on the decision-maker's reasonable apprehension that the exercise of the power is necessary in the circumstances;.**
- **The power to implement emergency plans be amended to ensure that it confers no powers other than those explicitly set out in Bill 138.**
- **Bill 138 be amended to provide that every emergency plan requires protocols for safe and speedy court access developed in consultation with the judiciary, and that the Courts of Justice Act be amended to ensure an early hearing for any proceeding under or in respect of emergency legislation or any action taken under it.**

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[484] R.S.O. 1990, c. H-1.

[485] R.S.O. 1990, c. L-10.

[486] R.S.O. 1990, c. H-19.

[487] R.S.O. 1990, c. E-6.

[488] R.S.O. 1990, c. C-43.

[489] For vagueness, see for instance Gonthier J. in R. *v. Nova Scotia Pharmaceutical Society* [1992] 2 S.C.R. 606 at para 69. For delegation of plenary discretion, see for instance *Irwin Toy Ltd. v. Quebec (A.G.)* [1989] 1 S.C.R. 927 at para 63.

- **The Attorney General's Department scrutinize Bill 138 intensely for transparency to ensure that it confers no hidden powers and that all powers conferred are clearly set out on the face of the statute.**
- **The basket clause s. 7.0.2(4)12 be reviewed on the same basis as that recommended above for the trigger and criteria and limitations, the basis of reasonable apprehension.**
- **Every emergency plan provide for a process to facilitate advance planning to address potential workplace health and safety issues and to work out those issues when they arise.**
- **Bill 138 be amended to provide:**
    - **That Bill 138 does not derogate from the powers authorized by any Ontario Statute or any ancillary or inherent authority.**
    - **That no order made or action purportedly taken under Bill 138 shall be set aside on grounds it is not authorized by the Act if the order or action is authorized by some other Ontario statute or inherent or ancillary power.**
    - **That no order made or action taken in response to a declared emergency under the purported authority of any Ontario statute or inherent or ancillary power shall be set aside for lack of legal authority if the order or action is authorized under Bill 138.**

Appendix A: First Interim Report Summary of Recommendations

A BROKEN SYSTEM

SARS showed that Ontario's public health system is broken and needs to be fixed. Despite the extraordinary efforts of many dedicated individuals and the strength of many local public health units, the overall system proved woefully inadequate. SARS showed Ontario's central public health system to be unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate.

The SARS crisis exposed deep fault lines in the structure and capacity of Ontario's public health system. Having regard to these problems, Ontario was fortunate that SARS was ultimately contained without widespread community transmission or further hospital spread, sickness and death. SARS was contained only by the heroic efforts of dedicated front line health care and public health workers and the assistance of extraordinary managers and medical advisors. They did so with little assistance from the central provincial public health system that should have been there to help them.

These problems need urgently to be fixed.

REASONS FOR INTERIM REPORT

The work of this Commission will continue until I am satisfied that the necessary evidence has been reviewed. Because government decisions about fundamental changes in the public health system are clearly imminent, this interim report on the public health lessons of SARS is being issued at this time instead of awaiting the final report. This interim report is based on the evidence examined to date and is not intended as the last word on this aspect of the Commission's investigation.

The fact that the Commission must address public health renewal on an interim basis is not to say it is more important than any other urgent issue such as the safety and protection of health care workers. It is simply a case of timing. The Commission continues to interview health care workers, SARS victims, the families of those who died, and those who fought the outbreak. Their story and the story of SARS will be told in the Commission's final report.

For an update on the Commission's ongoing work see Appendix A.

TWENTY-ONE PRINCIPLES FOR REFORM

The lessons of SARS yield 21 principles for public health reform:

1. Public health in Ontario requires a new mandate, new leadership, and new resources.

2. Ontario public health requires renewal according to the principles recommended in the Naylor, Kirby, and interim Walker reports.

3. Protection against infectious disease requires central province-wide accountability, direction, and control.

4. Safe water, safe food, and protection against infectious disease should be the first priorities of Ontario's public health system.

5. Emergency planning and preparedness are required, along with public health infrastructure improvements, to protect against the next outbreak of infectious disease.

6. Local medical officers of health and public health units, the backbone of Ontario public health, require in any reform process a strong focus of attention, support, consultation and resources.

7. Reviews are necessary to determine if municipalities should have a significant role in public health protection, or whether accountability, authority, and funding should be fully uploaded to the province.

8. If local boards of health are retained, the province should streamline the processes of provincial leadership and direction to ensure that local boards comply with the full programme requirements established by the province for infectious disease protection.

9. So long as the local boards of health remain in place: The local medical officer of health should have full chief executive officer authority for local public health services and be accountable to the local board. Section 67 of the *Health Protection and Promotion Act* should be enforced, if necessary amended, to ensure that personnel and machinery required to deliver public health protection are not buried in the municipal bureaucracy.

10. Public health protection funding against infectious disease should be uploaded so that the province pays at least 75 per cent and local municipalities pay 25 per cent or less.

11. A transparent system authorized by law should be used to clarify and regularize the roles of Chief Medical Officer of Health and the local medical officer of health in deciding whether a particular case should be designated a reportable disease.

12. The Chief Medical Officer of Health, while accountable to the Minister of Health, requires the independent duty and authority to communicate directly with the public and the Legislative Assembly whenever he or she deems necessary.

13. The operational powers of the Minister of Health under the *Health Protection and Promotion Act* should be removed and assigned to the Chief Medical Officer of Health.

14. The Chief Medical Officer of Health should have operational independence from government in respect of public health decisions during an infectious disease outbreak. Such independence should be supported by a transparent system requiring that any Ministerial recommendations be in writing and publicly available.

15. The local medical officer of health requires independence, matching that of the Chief Medical Officer of Health, to speak out and to manage infectious outbreaks.

16. The operational powers of the local medical officer of health should be reassigned to the Chief Medical Officer of Health, to be exercised locally by the medical officer of health subject to the direction of the Chief Medical Officer of Health.

17. An Ontario Centre for Disease Control should be created as support for the Chief Medical Officer of Health and independent of the Ministry of Health. It should have a critical mass of public health expertise, strong academic links, and central laboratory capacity.

18. Public health requires strong links with hospitals and other health care facilities and the establishment, where necessary, of an authoritative hospital presence in relation to nosocomial infections. The respective accountability, roles and responsibilities of public health care and health care institutions in respect of infectious outbreaks should be clarified.

19. Ontario and Canada must avoid bickering and must create strong public health links based on cooperation rather than competition to avoid the pitfalls of federal overreaching and provincial distrust.

20. The Ontario government must commit itself to provide the necessary resources and leadership for effective public health protection against infectious disease.

21. Public health requires strong links with nurses, doctors and other health care workers and their unions and professional organizations.

It is expected that the final report of the Walker expert panel will recommend a detailed prescriptive blueprint for many of the operational details of a renewed system. Such operational details are beyond the scope of this interim report. Some of the issues that will drive these details are discussed in the report.

HINDSIGHT

Everything said in this report is said with the benefit of 20-20 hindsight, a gift not available to those who fought SARS or those who designed the systems that proved inadequate in face of a new and unknown disease.

It is important to distinguish between the flaws of public health systems and the skill and dedication of those who worked within them. To demonstrate the weakness of Ontario's public health infrastructure is not to criticize the performance of those who worked within systems that proved inadequate in hindsight. The Commission recognizes the skill and dedication of so many individuals in the Ontario public health system and those volunteers from Ontario and elsewhere who worked beyond the call of duty. Twenty-hour days were common. They faced enormous workloads and pressures in their tireless fight, in a rapidly changing environment, against a deadly and mysterious disease.

It is my hope that those who worked on the front lines and in public health in Ontario during SARS will accept that I have approached the flaws of the system with the utmost respect for those who gave their all to protect the public. We should be humbled by their efforts.

In this interim report I have attempted to avoid, and I invite the reader to avoid, the unfair use of hindsight to judge the actions of those who struggled so valiantly in the fog of battle against the unknown and deadly virus that is SARS.

WHAT WENT RIGHT

The litany of problems listed below reflect weaknesses in central public health systems. These weaknesses hampered the work of the remarkable individuals who eventually contained SARS. The problems of SARS were systemic problems, not people problems. Despite the deep flaws in the system, it was supported by people of extraordinary commitment.

The strength of Ontario's response lay in the work of the people who stepped up and fought SARS. What went right, in a system where so much went wrong, is their dedication. It cannot, however, be said that things went right because SARS was eventually contained. It does nothing for those who suffered from SARS or lost loved ones to SARS to say that the disease which caused their suffering was ultimately contained. For the families of those who died from SARS and for all those who suffered from it, little if anything went right. This enormous toll of suffering requires that the Ontario government commit itself to rectify the deep problems in the public health system disclosed by SARS.

THE DECLINE OF PUBLIC HEALTH

The decline of public health protection in Ontario began decades before SARS. No government and no political party is immune from responsibility for its neglect.

It is troubling that Ontario ignored so many public health wake-up calls from Mr. Justice Krever in the blood inquiry, Mr. Justice O'Connor in the Walkerton Inquiry, from the Provincial Auditor, from the West Nile experience, from pandemic flu planners and others. Despite many alarm calls about the urgent need to improve public health capacity, despite all the reports emphasizing the problem, the decline of Ontario's public health capacity received little attention until SARS. SARS was the final, tragic wake-up call. To ignore it is to endanger the lives and the health of everyone in Ontario.

LACK OF PREPAREDNESS: THE PANDEMIC FLU EXAMPLE

When SARS hit, Ontario had no pandemic influenza plan. Although SARS and flu are different, the lack of a pandemic flu plan showed that Ontario was unprepared to deal with any major outbreak of infectious disease.

Had a pandemic flu plan been in place before SARS, Ontario would have been much better prepared to deal with the outbreak. The failure to heed warnings about the need for a provincial pandemic flu plan, and the failure to put such a plan in place before SARS, reflects a lack of provincial public health leadership and preparedness.

LACK OF TRANSPARENCY

Because there was no existing plan in place for a public health emergency like SARS, systems had to be designed from scratch. Ad hoc organizations like the epidemiological unit (Epi Unit) and the Science Committee were cobbled together. Procedures and protocols were rushed into place including systems like the case review, or adjudication process, that grew up to determine whether a particular case should be reported as SARS. Because SARS was such a difficult disease to diagnose, there were no reliable lab tests and knowledge about the disease was rapidly evolving, there were disagreements from time to time as to whether a particular case was SARS.

Although well meaning, this system lacked clear lines of accountability and in particular it lacked transparency.

To avoid this problem in the future the Commission recommends that the respective roles of the Chief Medical Officer of Health and the local medical officers of health, in deciding whether a particular case should be designated as a reportable disease, should be clarified and regularized in a transparent system authorized by law.

LACK OF PROVINCIAL PUBLIC HEALTH LEADERSHIP

Few worked harder during SARS than Dr. Colin D'Cunha, the Chief Medical Officer of Health for Ontario and Director of the Public Health Branch in the Ontario Ministry of Health and Long-Term Care. He demonstrated throughout the crisis a strong commitment to his belief of what was in the public interest. Dr. D'Cunha is a dedicated professional who has devoted his career to the advancement of public health. For the brief reasons set out in the report Dr. D'Cunha turned out in hindsight to be the wrong man in the wrong place at the wrong time.

While it may be due to misunderstandings or a simple difficulty on the part of Dr. D'Cunha to communicate effectively, there is a strong consensus on the part of those colleagues who worked with him during the crisis that his highest and best public calling at this time is in an area of public health other than direct programme leadership. This general concern has undoubtedly been reflected in the government's decision to provide him with other opportunities within his area of expertise.

Because Dr. D'Cunha no longer holds the office of Chief Medical Officer of Health it might be asked why it is necessary in this interim report to deal with his leadership during SARS. The answer is that the public has a right to know what happened during SARS and that obliges me to make whatever findings I am taken to by the evidence. The story of what happened during SARS cannot be told without some reference to the difficulties that arose in respect of Dr. D'Cunha's leadership.

I cannot fairly on the evidence before me make any finding of misconduct or wrongdoing by Dr. D'Cunha. The underlying problems that arose during SARS were systemic problems, not people problems. Because the underlying problems were about inadequate systems and not about Dr. D'Cunha, it would be unfair to blame him or make him a scapegoat for the things that went wrong.

It is impossible to say, in the end result, that Dr. D'Cunha's difficulties made any ultimate difference in the handling of the crisis. Although his colleagues were frustrated by his approach to things, the crisis was to a large extent managed around him. It is hard to say that the overall result of the SARS crisis would have been different with someone else at the helm.

LACK OF PERCEIVED INDEPENDENCE

The Commission on the evidence examined thus far has found no evidence of political interference with public health decisions during the SARS crisis. There is, however, a perception among many who worked in the crisis that politics were at work in some of the public health decisions. Whatever the ultimate finding may be once the investigation is completed, the perception of political independence is equally important. A public health system must ensure public confidence that public health decisions during an outbreak are free from political motivation. The public must be assured that if there is a public health hazard the Chief Medical Officer of Health will be able to tell the public about it without going through a political filter. Visible safeguards to ensure the independence of the Chief Medical Officer of Health were absent during SARS. Machinery must be put in place to ensure the Actual and apparent independence of the Chief Medical Officer of Health in decisions around outbreak management and his or her ability, when necessary, to communicate directly with the public.

LACK OF PUBLIC HEALTH COMMUNICATION STRATEGY

The problems of public communication during SARS are addressed thoughtfully in the Naylor Report and the Walker Interim Report. The Commission endorses their findings and their recommendations for the development of coherent public communication strategies for public health emergencies.

There is no easy answer to the public health communications problems that arose during SARS. On the one hand, if there are too many uncoordinated official spokespeople the public ends up with a series of confusing mixed messages. On the other hand, as Mr. Tony Clement the Minister of Health during SARS pointed out to the Commission, any attempt to manage the news by stifling important sources of information will not only fail but will also lead to a loss of public confidence and a feeling among the public that they are not getting the straight goods or the whole story. What is needed is a pre-planned public health communications strategy that avoids either of these extremes.

POOR COORDINATION WITH FEDERAL GOVERNMENT

Problems with the collection, analysis and sharing of data beset the effort to combat SARS. While many factors contributed to this, strained relations between the three levels of government did not help matters.

The lack of federal-provincial cooperation was a serious problem during SARS. This lack of cooperation prevented the timely transmission from the Ontario Public Health Branch of vital SARS information needed by Ottawa to fulfill its national and international obligations. Although recollections differ as to the responsibility for this lack of cooperation, the underlying problems were the lack of pre-existing protocols, agreements, and other machinery to ensure the seamless flow of necessary information and analysis, combined with a possible lack of collaborative spirit in some aspects of the Ontario response.

The inherent tensions between the federal and provincial governments must be overcome by a spirit of cooperation around infectious disease surveillance and coupled with the necessary machinery to ensure in advance that the vital information will flow without delay. It is clearly incumbent on both levels of government to ensure that the breakdown that occurred during SARS does not happen again.

A DYSFUNCTIONAL PUBLIC HEALTH BRANCH

The Commission has heard consistent reports that the Public Health Branch of the Ministry of Health had become dysfunctional both internally and in terms of its relationships with the local public health units.

A lack of respect for the Public Health Branch was evident in the responses from outside Ontario and from elements of the Ontario public health system at the local level. When

SARS hit, leadership was not forthcoming from a Public Health Branch that turned out to be dysfunctional.

LACK OF CENTRAL PUBLIC HEALTH COORDINATION

Under the *Health Protection and Promotion Act*, local medical officers of health were responsible for the local response to SARS. It was to the province however, to the Public Health Branch in the Ministry of Health, that the local public health units looked for guidance. Unfortunately many medical officers of health felt there was no coordinated effort at the Public Health Branch to facilitate the SARS response at the local level. For many in the field it seemed as though the Branch was a silo, disconnected from the field, rather than a partner or a resource.

Many local medical officers of health felt abandoned during SARS, devoid of support and guidance. The Branch's failure to coordinate and guide the local health units was already a big problem before SARS. It turned out to be a harbinger of the problems that arose during SARS.

LACK OF CENTRAL EXPERTISE

The outbreak was managed, of necessity, around the Public Health Branch of the Ministry of Health and Long-Term Care rather than through it. The critical mass of professional expertise one would expect in a crucial branch of government in a province the size of Ontario simply did not exist, either in the number of experts or their depth of experience. Key operational groups had to be put together on the run and individual experts had to be recruited from the field to fill this void. Machinery such as the Science Committee and the Epi Unit were run on almost a volunteer drop-in basis because there was no depth of expertise in the Branch itself.

SARS demonstrated that our most valuable public health resources are human resources and that Ontario lacked a critical mass of expertise at the provincial level. It is crucial to the success of any public health reform initiatives in Ontario that there be a high level of expertise at both the local and central levels of public health. Ontario cannot continue to rely on the goodwill and volunteerism of others to protect us during an outbreak. Many of those who came forward to work at the provincial level during SARS were disheartened by the problems they saw and a few expressed doubts whether they would be willing to come forward again, particularly if the problems are not addressed. Examples abound of centres of excellence for disease control: British Columbia, Quebec, and Atlanta, among others. Ontario needs to learn from their example. Without a critical mass of the right professionals public health reform, no matter how well-reasoned and well-resourced, has no chance of success.

NO ESTABLISHED SCIENTIFIC BACKUP

In March 2003, the Public Health Branch in Ontario had neither the capacity nor the expertise to handle an outbreak of the magnitude of SARS. Neither was there any provincial plan to rapidly bring together the necessary experts to provide scientific advice to those managing the outbreak. One outside expert, brought in to help manage the crisis, noted that Ontario simply didn't have the machinery, people or the leadership at the central level:

> It was abundantly clear to everyone who sat in on teleconferences that Ontario was scrambling, didn't have the infection control expertise, at least the amount of expertise. There were superb infection control people there … it's clear they were unable to pull together the data that was required for them and us to try to understand what's going on. It was abundantly clear that there was no obvious concerted leadership of the outbreak at least as we could see … It was obvious to all of us that Ontario was in substantial trouble.

Consequently, the Ministry of Health had to turn to experts outside of government for advice and direction. While it is not unusual that outside experts would be consulted during an outbreak, the lack of planning meant that the core expert groups had to be thrown together in haste without adequate planning or organization.

LACK OF LABORATORY CAPACITY

Before SARS, concerns had been raised about the capacity of the Ontario Central Public Health Laboratory (provincial laboratory). Despite these warnings, it was not prepared to deal with an outbreak of this magnitude. There were only two medical microbiologists in the laboratory, who were responsible for the entire province.

To make it worse, the Ministry of Health and Long-Term Care, in the fall of 2001, had laid off its PhD level scientists at the provincial laboratory. These scientists were engaged in the diagnosis and surveillance of new and emerging infections as well as research and development.

Within government, there seemed to be a complete lack of understanding of the importance of the work done by scientists at the provincial laboratory. At the time of the layoffs, a Ministry of Health spokesman was quoted as saying:

> Do we want five people sitting around waiting for work to arrive? It would be highly unlikely that we would find a new organism in Ontario.

It is unnecessary, in light of SARS, to bring the irony of this statement to the attention of the reader. Less than two years later, SARS struck Ontario. The provincial laboratory did not have the capacity to deal with SARS.

Despite earlier warnings, the Ontario Central Public Health Laboratory proved inadequate during SARS. It is essential that the provincial laboratory be revitalized with the necessary physical and human resources.

NO PROVINCIAL EPIDEMIOLOGICAL UNIT

When SARS hit Ontario, the Ministry of Health's Public Health Branch was totally unprepared to deal with an outbreak of this nature. To start with, it had no functioning epidemiological unit (Epi Unit).

The Science Committee needed epidemiological data about the transmission of the disease and whether control measures were effective. It needed answers to a number of vital questions: How was the outbreak progressing? What was the incubation period? How long were people infectious? What were the risks in hospital?

Although an Epi Unit was cobbled together as the outbreak unfolded, its work was hampered by the lack of planning and support systems.

It was a major failure of Ontario's public health system that no such unit was in place when SARS struck. The development of fully resourced epidemiological capacity is vital to protect Ontario against outbreaks of infectious disease. In the absence of major reform, Ontario may not be able in a future outbreak to draw on the extraordinary volunteer resources that helped so much in the spring of 2003.

INADEQUATE INFECTIOUS DISEASE INFORMATION SYSTEMS

The fight against SARS was hampered by the lack of an effective reportable disease information system. When SARS hit Ontario neither the provincial Public Health Branch nor the local public health units had any information system capable of handling a disease like SARS. The existing system, known as Reportable Disease Information System, or RDIS, was disease-specific and not flexible enough to handle new diseases.

Until the Epi Unit was up and running, there was no way to coordinate the work of local public health units into a common reporting structure. This delay turned out to be a critical problem. By the time the Epi Unit was established, individual health units were married to their own individual methods of collecting and reporting data. As a result, they were unable and disinclined to change their systems mid-stream, despite problems created by the diverse manner in which the data was being collected and reported.

Because of systemic weaknesses, the Toronto Public Health unit, which had the majority of the SARS cases, relied on a paper-based system of case tracking. This nightmarish system generated cardboard boxes spilling over with paper, all of which had to be collated and analyzed by hand.

The Commission endorses the specific recommendations in the Naylor Report and the Walker Interim Report to address the deficiencies in the federal and Ontario infectious disease information systems.

Should SARS or some other infectious disease hit Ontario tomorrow, the province still has no information system, accessible by all health units, capable of handling an outbreak. The first unheeded wake-up call was the Provincial Auditor's report in 1997. The second unheeded wake-up call was West Nile. If it takes Ontario as long to respond to SARS as it did to those earlier wake-up calls, the province will be in serious trouble when the next disease strikes.

OVERWHELMING AND DISORGANIZED INFORMATION DEMANDS

The problem of information flow was not restricted to the lack of the necessary information technology systems. Confusion, duplication, and apparent competition prevailed in the work of those in the central apparatus who sought information from local public health units and hospitals. These unfocused demands consumed valuable time of public health and hospital staff, distracted them from urgent tasks at hand, and impaired their ability to get on with the work of fighting the disease.

SARS caught Ontario with no organized system for the transmission of case information to those who needed it to fight the outbreak. There was no order or logic in the frenzied, disorganized, overlapping, repetitious and multiple demands for information from hospitals and local public health units. Requests would go out simultaneously to many people for the same piece of information. The work of front line responders in hospitals and health units was seriously impaired by this constant and unnecessary harassment.

INADEQUATE DATA

The data produced by the jerry-built system through the frenzy of information demands often proved to be inadequate. Accurate data of high quality was vital to the experts on the Science Committee who had to provide evidence- and science-based direction for the management of SARS. Because so much about the disease was unknown, case-specific information was vital and sound decisions could not be made without adequate data of the necessary quality.

The Science Committee never reached the point where it received adequate data in a timely manner, including information about contacts of those with SARS. Consequently, it was difficult to judge the effectiveness of control measures such as quarantine.

The Epi Unit and the local health units were often unable to provide adequate and timely data. While there is disagreement among those involved as to the amount of data being provided, what is clear is that the experts and officials who needed the data did not get what they needed when they needed it. The information systems and support structures were simply not in place. In the absence of this necessary machinery, not even the hardest work and greatest expertise of those who came forward to staff the Epi Unit and the Science Committee could overcome the obstacles

DUPLICATION OF CENTRAL DATA SYSTEMS

Because there was no standard information system for the Public Health Branch and all the local public health units, each individual health unit developed their own data collection system during SARS. The lack of a single, effective, accessible information system, combined with a constant, intense demand for information from a number of different people and groups, resulted in chaos.

Duplicate data systems sprung up at the Ministry of Health. For example, one group in the Ministry ran a system intended to track the situation in hospitals. This group collected data separate from the Epi Unit, but the numbers reported by this Ministry group often differed widely from the numbers reported by the Epi Unit.

The proliferation of data systems, and the confusion and burdens it created, was an inevitable consequence of Ontario's lack of preparedness for a major outbreak of infectious diseases.

Failure to priorize public health emergency preparedness, and to devise one central system for the collection and sharing of infectious disease data was a major problem during SARS. Although work has been done since SARS to improve the situation, there is no such system now in place to protect us from a future outbreak. Unless this problem is addressed, duplicate systems will spring up again as people scramble to devise their own information systems in the absence of systems put in place before the next outbreak hits.

BLOCKAGES OF VITAL INFORMATION

There was a perception among many who fought SARS that the flow of vital information to those who urgently needed it was being blocked or delayed for no good reason.

What is striking is that the various groups appear honestly to believe that they communicated the information to each other. Yet clearly there were significant gaps in the transfer of information between Toronto Public Health and the province, between the provincial Epi Unit and the Science Committee, and between Ontario and the Federal government. It is impossible to determine the precise source of the data blockages.

It does not matter whose perception, in the fog of battle against the disease, was correct. The bottom line is that the lack of clarity around the flow of communication and the reporting structure, the absence of a pre-existing epidemiological unit coordinated with the local health units and the absence of clear public health leadership above the Epi Unit provided an environment in which the crucial elements of the fight against SARS were disconnected from each other. Despite the best efforts of individuals attached to all of the groups involved, they simply could not connect effectively.

LEGAL CONFUSION

The fight against SARS was marked by the lack of clarity of existing laws that impacted on the public health system. Although the Commission cannot at this interim stage make specific recommendations for legislative reform in Ontario, a few things should be said about the general need for work in this area. Areas of concern include the following:

- Who legally was in charge of the outbreak?
- Who had the ultimate responsibility for the classification of a case: the local jurisdiction or the province?
- What was the legal authority for issuing directives to hospitals?
- What were the consequences of not following those directives?
- What specific information had to be transmitted, by whom, when and to whom?
- To what extent could public officials and private experts share data and for what purpose?
- Who was obliged to notify relatives that a family member was classified as a suspect or probable case?
- Did privacy rights prevent the sharing of information necessary to fight the outbreak?

While protection of patient confidentiality is a key consideration in any data sharing agreement or legislation, it should not in the future hinder the vital communication of data to the extent it did during SARS. Notwithstanding the strong privacy concern demonstrated by many of those who fought the outbreak, a number of families affected by SARS reported that they felt their privacy had nonetheless been violated because personally identifying information somehow made it into the media. It is ironic that although privacy concerns restricted the flow of vital information between agencies fighting the outbreak, they were not always effective to keep personal information from the media.

Whatever the precise path of legislative reform, privacy, while vital, should not impede the necessary sharing between agencies and governments of information required to protect the public against an outbreak of infectious disease.

The Commission during the course of its investigation will continue to address issues around the need for legislative changes identified in the lessons learned from SARS.

PUBLIC HEALTH LINKS WITH HOSPITALS

SARS was largely a hospital spread infection. Although there was some spread in households and doctors offices, and a limited element of community spread, most of the transmission took place in hospitals.

There are significant weaknesses in the links between public health and hospitals and there is lack of clarity as to the respective accountability and authority of public health and hospitals in a hospital-based outbreak.

Public health should have strong links with hospitals and establish where necessary an authoritative hospital presence in relation to nosocomial infection. The respective accountability, roles and responsibilities of public health and health care institutions in respect of infectious outbreaks should be clarified.

PUBLIC HEALTH LINKS WITH NURSES, DOCTORS AND OTHERS

Public health links with nurses, doctors, other health care workers and their unions and professional organizations were often ineffective during SARS.

This section of the report illustrates specific problems that arose from this general failure and points to the need for a better system to ensure that public health develops better links and communication systems with the key participants in the health care system.

LACK OF PUBLIC HEALTH SURGE CAPACITY: THE TORONTO EXAMPLE

The sudden demands imposed by SARS on local public health units were overwhelming. The hardest hit jurisdiction was Toronto, where the cases snowballed with each passing day of the outbreak. While the same was true of other public health units, Toronto is selected as an example because it had the greatest number of cases.

Despite the reassignment of public health staff from other jobs, and despite the influx of workers from other health units to help out, Toronto public health was at times overwhelmed by the staggering workload which included:

- Approximately 2,000 case investigations. Each took an average of nine hours to complete.
- More than 23,000 people identified as contacts.
- Of these, 13,374 placed in quarantine.
- More than 200 staff working on the SARS hotline.
- Over 300,000 calls received on the hotline.

- On the highest single day, 47,567 calls.

Despite the best efforts of so many, the systems for redeployment proved inadequate. SARS demonstrated the need to create surge capacity by planning in advance so that every available worker can be redeployed where necessary.

THE CASE OF THE FEDERAL FIELD EPIDEMIOLOGISTS

The federal government sent a number of Health Canada employees to work in the field to help with containment efforts. In the early days of the outbreak they sent three federal field epidemiologists to Toronto, often referred to as the field epi's, who brought a badly needed level of expertise to the provincial response. Unfortunately, the lack of clarity concerning their deployment and, from time to time, the tasks that they were asked to perform led to problems and ultimately contributed to the decision by Health Canada to pull them back from Ontario.

The case of the federal field epidemiologists demonstrates many of the underlying problems of Ontario's SARS response noted above: poor coordination among levels of government, poor coordination of Ontario's public health response, and above all a lack of any advance plan for outbreak management.

IMPROVEMENTS SINCE SARS

This section of the report describes the steps taken to fix the problems disclosed by SARS.

These pending and proposed improvements exemplify an obvious present desire to fix the public health problems revealed by SARS. It is beyond the Commission's mandate to evaluate or monitor these initiatives. The government's efforts to ensure the province will not again be confronted by the same problems that arose during SARS will be effective only if it dedicates adequate funds and makes a long-term commitment to reform of our public health protection systems. As in most areas of human endeavour, actions speak louder than words. Only time will tell whether the present commitment will be sustained to the extent necessary to protect Ontario adequately against infectious disease.

NAYLOR, KIRBY, WALKER

These three reports share a common vision for the renewal of our public health systems through increased resources, better federal-provincial and inter-agency cooperation, and system improvements. They bear close study and great consideration. Their methodology and approach are sound and their recommendations are solidly based in their respective expertise. Based on the evidence it has seen, the Commission endorses the major findings and recommendations of all three studies.

FEDERAL-PROVINCIAL COOPERATION

Too many good ideas in this country have been destroyed by mindless federal-provincial infighting. The most noble and appealing proposals for reform falter so often in Canada simply because of the inherent bureaucratic and political mistrust between the two levels of government. If a greater spirit of federal-provincial cooperation is not forthcoming in respect of public health protection, Ontario and the rest of Canada will be at greater risk from infectious disease and will look like fools in the international community. While there are hopeful signs that more cooperation will be forthcoming, it will take hard work from both levels of government to overcome the lack of coordination demonstrated during SARS.

Ontario and Canada must avoid bickering and must create strong public health links based on cooperation rather than competition, avoiding the pitfalls of federal overreaching and provincial distrust

INDEPENDENCE AND ACCOUNTABILITY

There is a growing consensus that a modern public health system needs an element of independence from politics in relation to infectious disease surveillance, safe food and safe water, and in the management of infectious outbreaks.

Whatever independence may be required by the Chief Medical Officer of Health for public health decisions during an outbreak and for the right to speak out publicly whenever necessary, he or she should remain accountable to the government for overall public health policy and direction and for the expenditure of public funds.

The proposed power to report directly to the public, combined with independence in relation to the management of infectious outbreaks, provides a significant measure of independence to the Chief Medical Officer of Health. It ensures that on important public health issues the Chief Medical Officer of Health cannot be muzzled and that the public can get a direct sense of emerging public health problems without passing through any political filters. It ensures both the reality and the public perception that the management of infectious disease outbreaks will be based on public health principles and not on politics.

The Commission therefore recommends:

- Subject to the guarantees of independence set out below, the Chief Medical Officer of Health should retain a position as an Assistant Deputy Minister in the Ministry of Health and Long-Term Care.

- The Chief Medical Officer of Health should be accountable to the Minister of Health with the independent duty and authority to communicate directly with the public by reports to the Legislative Assembly and the public whenever deemed necessary by the Chief Medical Officer of Health.

- The Chief Medical Officer of Health should have operational independence from government in respect of public health decisions during an infectious disease outbreak, such independence supported by a transparent system requiring that any Ministerial recommendations be in writing and publicly available.

- The local medical officer of health should have the independence, matching that of the Chief Medical Officer of Health, to speak out and to manage infectious outbreaks.

THE PUBLIC HEALTH PING-PONG GAME

Public health in Ontario including protection against infectious disease is delivered primarily through 37 local Boards of Health, which are largely controlled by municipal governments. Public health funding has gone back and forth like a ping-pong ball between the province and the municipalities.

So long as the municipalities fund public health to a significant degree, public health will have to compete with other municipal funding priorities. Communicable disease control is a basic public necessity that can affect the entire province if a disease gets ahead of the controls. Infectious disease control should not have to compete against potholes for scarce tax dollars.

There is no scientific way to determine the appropriate degree of provincial funding upload for infectious disease surveillance and control. Although a case can be made for 100-per-cent funding upload, the persuasive views of a number of local Medical Officers of Health suggest that it would be sensible to upload infectious disease control to a provincial contribution of at least 75 per cent.

Opinions will differ as to how the funding formula should be changed, and whether and how much coordinating or direct power over public health should be uploaded to the province. The one thing on which everyone will agree is that the shifting of funding and accountability back and forth between the province and the municipalities has impaired the stability of Ontario's public health system. It is time to stop the ping-pong game and to begin an era of stable public health funding relationships between the province and the municipalities.

ONE LOCAL FUNDING PROBLEM

This section of the report demonstrates in exquisite detail the problems that can arise through the present system of local funding of public health and the disinterest shown by some municipal politicians in the public interest in effective public health protection.

This story painfully reveals the importance of ensuring that funding for local health activities is not left to the mercies of any intransigent local council that fails to live up to its legal responsibilities in respect of public health protection. Basic protection against disease should not have to compete for money with potholes and hockey arenas. Even if most municipalities respect their public health obligations under the *Health Protection and Promotion Act,* it only takes one weak link to break the chain of protection against infectious disease. Should an infectious disease outbreak spread throughout Ontario, the municipality that cannot or will not properly resource public health protection may be the weak link that affects the entire province and beyond.

THE MUNICIPALITIES' FUNDING DILEMMA

All municipalities are affected by the underlying difficulty of funding any provincial programme from the local municipal property base. SARS and West Nile showed that infectious disease protection has to be approached at a provincial level. It is anomalous to fund a provincial programme like infectious disease control from the limited municipal tax base. In a submission to the Commission, the Association of Municipalities of Ontario makes a persuasive case for the province and the municipalities to sit down together and agree on the best structure to fund infectious disease protection and the best process for getting there.

ONE LOCAL STORY: PARRY SOUND

SARS was not restricted to Toronto. This section outlines the response to SARS by the local hospital, the West Parry Sound Health Centre and the local public health unit. It demonstrates the lack of provincial public health support to a local community faced with SARS and the difficulties caused by the inability of many local public health units to attract and retain permanent a medical officer of health.

If the present system of local control over public health and infectious disease is to be maintained, it is essential that machinery be put in place to ensure continuous unbroken oversight and authority in every public health unit in Ontario supported by the necessary cadre of public health professionals.

AN ONTARIO CENTRE FOR DISEASE CONTROL

A consensus has developed that some kind of separate "CDC Ontario" is needed, with strong academic links, in order to provide a critical mass of medical, public health, epidemiological, and laboratory capacity and expertise. Structural models abound for such an organization, from the British Columbia Centre for Disease Control (B.C. CDC), to the Institut national de santé publique du Québec, to the federal model proposed in the Naylor Report, and even to the United States Centres for Disease Control (CDC) itself. It is expected that the final Walker Report will make detailed and prescriptive recommendations for the structure and mandate of such an organization.

While it is beyond the scope of this interim report to address this issue in the detailed fashion expected from the final Walker report, a few observations are in order.

First, the structure of the new agency or centre, which will combine advisory and operational functions, must reflect the appropriate balance between independence and accountability whether it is established as a Crown corporation or some other form of agency insulated from direct Ministerial control.

Second, it should be an adjunct to the work of the Chief Medical Officer of Health and the local medical officers of health, not a competing body. SARS showed that there are already enough autonomous players on the block who can get in each other's way if not properly coordinated. There is always a danger in introducing a semi-autonomous body into a system like public health that is accountable to the public through the government. The risk is that such a body can take on a life of its own and an ivory tower agenda of its own that does not necessarily serve the public interest it was designed to support.

Third, it must be made clear from the beginning that the agency is not an end in itself but exists only to support public health.

The success of centres such as the CDC in Atlanta and the CDC in British Columbia flows largely from a widespread recognition that these institutions house the very best of the best. The authority they have comes from their recognition as centres of excellence that can be counted on to work collaboratively with local agencies. To achieve this authority and success an Ontario Centre for Disease Control will require considerable resources and a strong commitment from government to maintain those resources. It will only work if it has the resources to attract recognized experts and to provide them with the best technology and equipment and optimal support to perform their work. It will take years to build a reputation for excellence and anything less than a 100 per cent commitment to this long-term goal will surely result in failure.

PUBLIC HEALTH RESTRUCTURING

Whenever a system proves wanting it is tempting to blame its problems on structure and to embark on a course of reorganization, or centralization, or regionalization, or decentralization. It must be remembered that organizational charts do not solve problems. The underlying problems of public health in Ontario have to do with a lack of resources, years of neglect, and lack of governmental priority. These problems developed during the regimes of successive governments and no government or political party is immune from responsibility for the decline of public health protection. These problems will not be fixed by drawing boxes on paper around public health units and moving them into other boxes. The underlying problems will only be solved by a reversal of the neglect that has prevailed for so many years throughout the regime of so many different governments headed by all three political parties.

That being said some attention must be given to the best way to structure and organize the delivery of public health in Ontario. This section discusses the respective merits of different approaches to the restructuring of Ontario's system of public health protection.

GREATER PRIORITY FOR INFECTIOUS DISEASE CONTROL

SARS made it clear that our public health system must give greater priority to protection against infectious disease. It is equally clear, however, that our entire public health system cannot be reorganized around one disease like SARS. Many diseases produce more sickness and mortality than SARS, and the task of plugging the holes demonstrated by SARS cannot be permitted to detract public health from the task of preventing those afflictions that comprise a higher burden of disease than SARS and other infectious diseases.

While it would be wrong to downgrade the long-term importance of health promotion and population health, the immediate threat posed by any infectious outbreak requires that a dominant priority must be given to protecting the public against infectious disease. It does not disrespect the advocates of health promotion to say that the immediate demands of public safety require that public health, as its first priority, looks after its core business of protecting us from infectious disease.

The tension in public health, between priority for infectious disease control and priority for long-term population health promotion, including the prevention of chronic lifestyle diseases, is not going to go away. There is no point in arguing which is more important, because they are both important. There are however five basic reasons why protection against infectious disease should be the first basic priority of our public health system.

The first is that the threat from infectious disease is direct and immediate. The second is that an outbreak of infectious disease, if not controlled, can bring the province to its knees within days or weeks, a threat not posed by lifestyle diseases. The third is that infectious disease catches the direct attention and immediate concern of the public in a way that long-term health promotion does not. It is essential in an infectious disease outbreak that the public be satisfied that they are getting solid information from the government and that everything possible is being done to contain the disease. The fourth is that infectious disease prevention requires an immediate overall response because it moves rapidly on the ground and spreads quickly from one municipality to another and from province to province and country to country, thus engaging an international interest. The fifth is that health promotion depends largely on partnerships outside the health system between public health and local community agencies like schools and advocacy groups, allies and resources not available to infectious disease control which must stand largely on its own.

For these five reasons safe water, safe food, and protection against infectious disease should be the first priorities of Ontario's public health system.

CENTRAL CONTROL OVER HEALTH PROTECTION

An uncontrolled outbreak of infectious disease could bring the province to its knees. The province-wide consequences of a failure in infectious disease control are simply too great for the province to delegate infectious disease protection to the municipal level without effective measures of central provincial control. There is little machinery for direct central control over infectious disease programmes. The existing machinery to enforce local compliance with provincial standards is cumbersome and underused. Better machinery is needed to ensure provincial control over infectious disease surveillance and control.

During a disease outbreak the international community and organizations like the World Health Organization look for reassurance and credibility to the national and provincial level, not to the particular strength of any local public health board or the particular credibility of any local Medical Officer of Health. Viruses do not respect boundaries between municipal health units. The chain of provincial protection against the spread of infectious disease is only as strong as the weakest link in the 37 local public health units. A failure in one public health unit can spill into other public health units and impact the entire province and ultimately the entire country and the international community. When dealing with a travelling virus, concerns about local autonomy must yield to the need for effective central control.

If the *Health Protection and Promotion Act* were amended to provide that:

- The powers now assigned by law to the medical officer of health are reassigned to the Chief Medical Officer of Health, and
- The powers reassigned to the Chief Medical Officer of Health shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health,

it would leave to the local medical officers of health a clear field to exercise the same powers they have always exercised, subject to ultimate central direction.

Under the old system, such a re-arrangement of powers might raise serious concerns of loss of autonomy on the part of the local medical officer of health including the spectre of political influence from Queen's Park on local public health decisions. While concerns about local autonomy will never go away in any centralized system, the new independence of the Chief Medical Officer of Health and the medical officer of health should go a long way to allay such concerns.

A further sensible measure to allay these concerns, and to further protect against the perception of political interference with public health decisions, would be to remove from the Minister of Health under the Act the direct operational power in cases of health risk, such powers to be assigned to the Chief Medical Officer of Health.

These measures are proposed to strengthen provincial control over public health protection with adequate safeguards to ensure the political independence of the Chief Medical Officer of Health and the local medical officer of health in relation to infectious disease control.

Without stronger measures to ensure central provincial control of infectious disease control whenever necessary, Ontario will be left with inadequate protection against potential public health disasters.

POLITICAL WILL

A reformed public health system requires a major injection of resources. The Naylor, Kirby, and interim Walker reports analyzed the need for a critical mass of scientific and medical expertise, more capacity to educate, recruit, and retain public health professionals, increased laboratory capacity, and improved technology. Further recommendations are expected in the final Walker report. Significant financial resources will be needed to give Ontario's public health system any reasonable capacity for protection against infectious disease.

The decline of public health protection in Ontario reflects a consistent lack of political will, over the regime of many successive governments and all three political parties, to bring up to a reasonable standard the systems that protect us against infectious disease.

Competition for tax dollars is fierce. It is not easy in a time of fiscal constraint for any government to make additional funds available for any public programme. It will require significant political will on the part of the Minister of Health and the Ontario government to commit the funds and the long-term resolve that are required to bring our public health protection against infectious disease up to a reasonable standard.

It would be very easy, now that SARS is over for the time being, to put public health reform on the back burner. It is a general habit of governments to respond to a crisis by making a few improvements without fixing the underlying problems responsible for the crisis. It would be a tragedy if that turned out to be the case with SARS. As the Naylor Report pointed out:

> SARS is simply the latest in a series of recent bellwethers for the fragile state of Canada's … public health systems. The pattern is now familiar. Public health is taken for granted until disease outbreaks occur, whereupon a brief flurry of lip service leads to minimal investments and little real change in public health infrastructure or priorities. This cycle must end.[490]

Ontario, as demonstrated in this interim report, slept through many wake-up calls. Again and again the systemic flaws were pointed out, again and again the very problems that emerged during SARS were predicted, again and again the warnings were ignored.

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[490] National Advisory Committee on SARS and Public Health, *Learning from SARS: Renewal in Public Health in Canada* (Health Canada: October 2003) p. 64. (Subsequent footnotes will refer to this report as the Naylor Report.)

The Ontario government has a clear choice. If it has the necessary political will, it can make the financial investment and the long-term commitment to reform that is required to bring our public health protection against infectious disease up to a reasonable standard. If it lacks the necessary political will, it can tinker with the system, make a token investment, and then wait for the death, sickness, suffering, and economic disaster that will come with the next outbreak of disease.

The strength of the government's political will can be measured in the months ahead by its actions and its long-term commitments.

Appendix B: What Has Been Done

In June 2004, two months after the release of the Commission's first interim report and of the Walker panel's final report, the government unveiled Operation Health Protection, a three-year plan to fix the weaknesses in the public health system exposed by SARS.

The Ministry has recently updated the Commission on the status of efforts to revive the public health system. While this Appendix summarizes the Ministry's information on the progress to date in implementing key initiatives, it is beyond the Commission's mandate or resources to monitor their implementation.

Operation Health Protection announced that a new Health Protection and Promotion Agency will be created by 2006/7. It stated:

> Within two years, Operation Health Protection will be anchored by an independent health protection and promotion agency similar to those operating in British Columbia, Québec and at the Centers for Disease Control and Prevention in Atlanta. This new Ontario Health Protection and Promotion Agency will support the CMOH and provide expert scientific leadership.
>
> Its responsibilities will include:
>
> - **Specialized public health laboratory services** that will ensure that all health practitioners receive timely and relevant information to support health surveillance;
> - **Infection control and communicable disease information and centralized support** for professionals in "the field";
> - **Emergency preparedness assistance and support** in the form of scientific and technical advice, and a modern and timely alert system;
> - **Risk communications** that will enhance the rapid exchange of information between health care practitioners, institutions and the Ministry about potential health crises;
> - **Research and knowledge transfer** through linkages with research, academic and health care institutions; and
> - **Reporting** through the CMOH on the health status of Ontarians, and emergent health threats and risks.[491]

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[491] Operation Health Protection, p. 5.

The Ministry advises the Commission that a task force to help design and develop the agency has been struck, and its terms of reference confirmed and approved. The task force is expected to present initial recommendations to the Ministry by the spring of 2005 and make final recommendations by the fall of 2005.

One of the key weaknesses identified during SARS was the woeful lack of public health laboratory capacity in Ontario, a shortcoming that seriously hampered the response to the deadly outbreak. After years of neglect, SARS demonstrated that the Central Public Health Laboratory was severely under-staffed, poorly resourced, inadequately equipped, and badly led.

In response, Operation Health Protection stated that the Ministry intended to address the staffing issues, modernize the public health laboratory system and integrate it into the new Health Protection and Promotion Agency: It stated:

> Central to the establishment of the Agency is the modernization of Ontario's Central Public Health Laboratory and the public health laboratory system. Laboratories are a key element of an effective public health system. They are often the first indication of evidence of a reportable or communicable disease, a point of verification in the diagnosis of many diseases for which surveillance is essential, including infectious diseases.
>
> The Agency Implementation Task Force will also guide an operational review of the public health laboratory system to align the available testing services with what is required. This will also help determine the functional and procedural enhancements needed to ensure that the system performs at optimal levels on a daily basis as well as during an outbreak. This review will be completed over the next few months. Formal linkages are already being strengthened and technological infrastructure has recently been created within the Ministry and the Central Public Health Laboratory to improve communication and information exchange.
>
> Our goal is to ensure a state-of-the-art public health laboratory system in Ontario. In order to strengthen the province's laboratory capacity and to prepare for co-locating appropriate functions of the Central Public Health Laboratory with the Agency, we will enhance the medical capacity of the public health laboratory system, beginning with the addition of a senior medical director and additional medical microbiologist.[492]

The Ministry has advised that it has issued a Request for Proposals for an operational review of the public health laboratory system. The review is to have a number of key areas of focus including corporation organization and infrastructure and business practices and policies. With regards to staffing levels, the Ministry also advises that approval has been given for the recruitment of medical microbiologists and a medical director for the Central Public Health

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[492] *Ibid*, p. 13.

Laboratory. Recruitment is at the interview stage. In addition, the Ministry has advised that the Public Health Division is developing a closer functional relationship with the public health laboratory system.

The Commission's first interim report and the Walker panel's final report both recommended increasing the role and independence of the Chief Medical Officer of Health.

Operation Health Protection stated:

> As the most senior public health official in Ontario, the CMOH must be able to provide leadership while at the same time be able to speak publicly about public health issues. In addition, the CMOH must have an appropriate level of independent authority to act quickly and decisively in situations that pose risks to the health of Ontarians. To this end, over the coming year we will initiate legislative changes to increase the independence of the CMOH. Furthermore, the CMOH will be given the responsibility of providing an annual report on the health of Ontarians.[493]

On October 14, 2004, Bill 124, aimed at strengthening the role and independence of the Chief Medical Officer of Health, was introduced in the Ontario Legislature. It received Royal Assent on December 16, 2004. Under Bill 124, the Chief Medical Officer of Health can only be removed from office for cause on the address of the Legislative Assembly; some operational powers in the *Health Protection and Promotion Act* were reassigned from the Minister to the Chief Medical Officer of Health; the Chief Medical Officer of Health was given the authority to issue any reports on public health issues that he or she felt were appropriate; and the Chief Medical Officer of Health was mandated to issue one report each year on the state of public health in Ontario. The first report is expected in the 2005-6 fiscal year.

The SARS Commission and the Walker Panel both commented on the Public Health Division's lack of internal resources and capacity. In addressing these concerns, the Ministry has advised that an external organizational review has been completed. To strengthen the Division's internal capabilities, recruitment has begun for an Associate Chief Medical Officer of Health and Director of the Division's Infectious Diseases Branch (formerly known as the Division's Public Health Branch), and for six senior medical consultants. The Ministry indicates that a commitment has been made to rebuild public health capacity through the promotion of public health careers, the enhancement of training for public health professionals, the development of models for the effective utilization of human resources during an emergency and supporting strategies to increase full-time employment for nurses and other health care workers.

A committee has been created to review the capacity of local public health units. An interim report is expected in the summer of 2005 with the final report released in December 2005. Chaired by Dr. Susan Tamblyn, former medical officer of health for the Perth District

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[493] *Ibid*, p. 14.

Health Unit, the Capacity Review Committee is to advise the Chief Medical Officer of Health on the following:

- Core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer);
- Issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);
- Identifying operational, governance and systemic issues that may impede the delivery of public health programs and services;
- Mechanisms to improve systems and programmatic and financial accountability;
- Strengthening compliance with the *Health Protection and Promotion Act*, associated Regulations and the Mandatory Health Programs and Services Guidelines;
- Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.

The government says it expects to fully implement the Capacity Review Committee's recommendations by the 2006-7 fiscal year.

Adequate funding for local public health was an important issue raised in the wake of SARS. To address this, the province's share of local public health funding rose in January 2005 from 50 per cent to 55 per cent. It will rise to 65 per cent in 2006 and to 75 per cent in 2007.

Responding to numerous concerns about the Mandatory Health Programs and Services Guidelines, the Public Health Division intends to conduct a review of the Mandatory Health Programs and Services Guidelines. The review will consider emerging health issues, best practices, new science, as well as lessons learned from Ontario's experiences with Walkerton, West Nile virus and SARS.

SARS demonstrated the need to have a permanent panel of experts to advise the Chief Medical Officer of Health on the prevention and containment of infectious disease outbreaks. In an effort to fill this need, Operation Health Protection stated:

> The Ministry is creating a permanent central expert body – the Provincial Infectious Disease Advisory Committee (PIDAC) – to continue the development of standards and guidelines for health professionals and organizations faced with infectious disease outbreaks. Membership of the committee will bring together broad expertise from across the health care sector. The Committee will also advise on research priorities, emergency preparedness and immunization programs. PIDAC will help create regional networks for infection control and communicable disease that will coordinate infection control activities at the local level.[494]

The Ministry recently advised that the Provincial Infectious Diseases Advisory Committee (PIDAC) has been established. Its key role will be to advise the Chief Medical Officer of Health on prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases. PIDAC also provides the Chief Medical Officer of Health with advice on issues such as standards and guidelines for infection control, emergency preparedness for an infectious disease outbreak, protocols to prevent and control infectious diseases, and immunization programmes. Subcommittees have been created for surveillance, immunization and infection control. PIDAC has completed a best practice manual for the prevention and control of *Clostridium difficile* in health care facilities. PIDAC is currently co-chaired by Dr. David Williams, Medical Officer of Health for Thunder Bay District, and Dr. Dick Zoutman, Chief of the Department of Medical Microbiology and Medical Director of Infection Control Services, Kingston General Hospital.

The Ministry advises that foundational work is also under way to implement and assess a small number of regional infection control networks. Implementation of networks across the province is expected to be completed by the fiscal year 2006-7. As well, a steering committee has been created to develop tools for standardized and accessible infection control education to front line health care workers.

In the view of many, including the Commission, the fight against SARS was hampered by a lack of an effective reportable disease information system. To address this issue, the Ministry has pledged to implement a federally funded outbreak management system called the Integrated Public Health Information System or iPHIS. Operation Health Protection stated:

> A key component of this comprehensive public health information system is the Ministry's integrated Public Health Information System (iPHIS). This system builds on the federal initiative to integrate public health information and data systems across Canada, and will enhance both Public Health Unit reporting of reportable diseases and ability to manage outbreaks. Through iPHIS, health units will forward information on cases of reportable diseases to the Ministry, where it will be collected and quickly analyzed and interpreted to identify unusual and unexpected instances of infectious disease. This analysis will then be provided back to the Public Health Units

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[494] *Ibid*, p. 6

> to guide their activities and follow-up. Phase 1 (Testing and Evaluation) of the iPHIS implementation plan is complete and Phase 2 (Outbreak Management and Ontario Enhancements) will begin in November of this year. Within one year, iPHIS will be fully implemented in all Public Health Units for communicable disease reporting, contact tracing, and quarantine management.[495]

We are informed by the Ministry that full deployment of the iPHIS system is expected to be completed by the end of 2005.

The Emergency Management Unit (EMU) is overseeing the development of the Ontario Health Pandemic Influenza Plan, which was first issued in May 2004. The Commission understands that a steering committee, and a number of subcommittees and working groups, have been established to refine the plan. The Public Health subcommittee and related working groups, for example, have developed draft guidelines for laboratory surveillance during a pandemic. The Operations subcommittee and related working groups, for their part, are developing a provincial framework for the delivery of necessary health services during a pandemic.

The Ministry has told the Commission that efforts are also under way to develop a pan-governmental approach to pandemic planning. A series of exercises are planned in 2005 in collaboration with Health Canada and the other provinces and territories to test parts of the Canadian Pandemic Influenza Plan.

Additionally, the EMU is working on a smallpox emergency response plan, business continuity plans, the health component of the Foreign Animal Disease Plan and a radiation health response plan. It has also participated in a number of emergency management exercises. EMU also participated in a number of emergency management exercises in 2004.

In January 2005, the government announced a $13.5 million programme to help hospitals respond to chemical, biological, radiological and nuclear emergencies. Funds will be used to purchase self-contained decontamination tents, build emergency stockpiles of equipment and supplies, train staff and conduct emergency exercises.[496]

Efforts are also being made to improve accountability and enforcement in the delivery of public health services and programmes.

In a newly released financial planning and accountability guide for boards of health and health unit staff, the Ministry's Public Health Division has advised that it will actively enforce compliance with the Mandatory Health Programs and Services Guidelines.

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[495] *Ibid*, p. 22.

[496] Canada News Wire, Operation Health Protection' Giving Hospitals Improved Training And Emergency Supplies, January 13, 2005.

According to the guide, the Ministry is also implementing a performance measurement system for local public health units. This system – together with grant request documents and related reporting requirements – are intended to strengthen the Ministry's ability to monitor program funding and service delivery. In describing transfer payment accountability, the guide stated:

> Transfer payments involve an agreement between the Province and the applicable health unit. The Ministry must ensure that prior to advancing any provincial funds to health units, signed agreements are in place that:
>
> - Bind the health unit to achieve specific, measurable results per the Mandatory Health Programs and Services Guidelines;
> - Require health units, as a condition of funding to have in place governance and administrative structures and processes necessary to ensure prudent and effective management of public funds;
> - Require health units to provide periodic reports on financial status and relevant financial and program results achieved;
> - Clearly establish the province's right to require independent verification of reported information by independent professionals;
> - Limit the obligations of the province according to the terms of programs approved by Cabinet; and
> - Permit the recovery of provincial funds and/or the discontinuance of ongoing funds in the event of health unit non-performance.
>
> **Monitoring and Reporting**
>
> The Ministry is required to obtain and review information on the status of health unit eligibility and performance and identify non-compliance with agreements and the failure of health units to demonstrate continued eligibility.

Complementing these initiatives is an increased role of the Auditor General (formerly called the Provincial Auditor.) The aforementioned guide advised boards of health and health unit staff that Bill 18, *An Act Respecting the Provincial Auditor,* received Royal Assent in November 2004. It expands the mandate of the Auditor General to conduct discretionary value-for-money[407] audits of local boards of health. Section 9.1 of the Act states:

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[407] According to the web site of the Auditor General: "An extremely important part of the Auditor General's mandate is the value-for-money component. Value-for-money audits are assessments of whether or not money was spent with due regard for economy and efficiency and whether appropriate procedures were in place to measure and report on the effectiveness of government programs. Under the *Auditor General Act*, the Office is required to report to the Legislature significant instances where it is observed that the government is not

> 9.1(1) On or after April 1, 2005, the Auditor General may conduct a special audit of a grant recipient with respect to a reviewable grant received by the grant recipient directly or indirectly on or after the date on which the *Audit Statute Law Amendment Act, 2004* receives Royal Assent.
>
> Exception
>
> (2) Subsection (1) does not apply with respect to a grant recipient that is a municipality.

However, while the Auditor General does not have the mandate to audit municipalities, s. 9.2 of the Act does provide the following authority with regards to municipal grants:

> 9.2(1) The Auditor General may examine accounting records relating to a reviewable grant received directly or indirectly by a municipality.
>
> (2) The Auditor General may require a municipality to prepare and submit a financial statement setting the details of its disposition of the reviewable grant.

The Ministry indicated that it has also established the Public Health e-Health Council, cochaired by Dr. Basrur and Dr. George Pasut, the Medical Officer of Health for Simcoe County. The council has 14 members, including physician, hospital, continuing care and laboratory representatives. The council's mandate is to provide a forum for the discussion of e-health issues in the public health sector and to provide leadership and advice in resolving them.

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fulfilling its responsibilities in these areas. To fulfill its value-for-money mandate, the Office annually conducts audits of selected ministry or agency programs and activities. Major programs and activities are generally audited every five years or so. Every year, senior management of the Office consider a number of risk factors when selecting which programs to audit in the coming audit period. These factors include: the results of previous audits, the total revenues or expenditures at risk, the impact of the program or activity on the public, the inherent risk due to the complexity and diversity of operations, the significance of possible issues that may be identified by an audit, and the costs of performing the audit in relation to the perceived benefits. The results of value-for-money audits are reported on in the Auditor General's Annual Report and constitute a large portion of that document. As well, of all the observations that the Auditor General reports on, value-for-money findings tend to attract the largest proportion of media coverage and interest from the public and from the Standing Committee on Public Accounts."
(See http://www.auditor.on.ca/english/aboutus/whatwedo_frame.html).

Appendix C: Commission Process and Ongoing Work

The Commission was appointed by Order in Council dated June 10, 2003. Some preliminary interviews were conducted in June and July[498] and the work got fully under way in August after premises were secured and a small core of staff had been retained.

On April 15, 2004, the Commission provided to the Minister of Health an interim report titled *"SARS and Public Health in Ontario."* That interim report was based upon the public health aspects of the SARS crisis that had emerged from the evidence obtained during the course of investigation to that date.

Following the release of the first interim report, the Commission continued to interview witnesses and review documents. That work will continue beyond this second interim report in order to tell the public the story of SARS, what happened, what went right, what went wrong, and what lessons emerge from the entire experience. The specific terms of reference, to be addressed in the final report, are set out in Appendix F. These issues include, among others, infection control in hospitals, health worker protection and occupational health and safety in hospitals. Many who contracted SARS and who lost family members to SARS have spoken to the Commission with particular concerns, which will be addressed in the final report.

For this interim report, in addition to the interviews, the Commission in July, sent letters to 55 institutions and individuals, including hospitals, public health units, professional organizations and government. Many responded with thoughtful insights and recommendations. The responses provide invaluable information and great assistance to the Commission. Not all have been incorporated in this interim report. Some recommendations were outside the scope of this interim report and will be considered for the final report.

Most of the Commission's investigation takes place through confidential interviews. Over 400 interviews have been held on the condition that those interviewed will not be identified by name in the report and that their disclosure to the Commission is confidential and not subject to private or public access.

The Commission is grateful to those who have come forward to provide information and in particular to the many who suffered from SARS and lost family members to SARS, who shared their stories despite the pain of reliving their suffering and loss. The Commission will speak to more SARS victims in the months ahead including those who lost loved ones to SARS.

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[498] During June and into July the health care system was still dealing with SARS patients and public health authorities were still dealing with SARS issues. It was required by the terms of reference, and by common sense, that the investigation be conducted in a manner that does not impede ongoing efforts to isolate and contain SARS.

The Commission will continue to conduct interviews in the months to come. Anyone who wishes to speak to the Commission should contact Commission Counsel, Mr. Douglas Hunt, Q.C., (416-212-6868) or Assistant Commission Counsel, Ms. Jennifer Crawford (416-212-6867).

In addition to the private interviews, the Commission held six days of public hearings. The first round of public hearings were held on September 29, 30 and October 1 at the St. Lawrence Market (North Market) in Toronto. The second round of hearings were held on November 17, 18 and 19, at the St. Lawrence Hall, in Toronto. Everyone who asked to present to the Commission was given an opportunity to be heard. Over one hundred people spoke publicly during these six days of public hearings.

Transcripts of the presentations, along with some of the power point presentations and written submissions provided to the Commission by presenters during the public hearings, are available for public viewing at the Commission web site: www.sarscommission.ca.

There is no deadline for the completion and submission of the final report. The work will continue until the Commissioner is satisfied that all necessary evidence has been reviewed and that the terms of reference have been fulfilled. For further information or future updates on the work of the Commission, please visit our web site at www.sarscommission.ca.

Appendix D: Letter of Appointment

Ministry of Health
and Long-Term Care

Office of the Minister
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
Tel: 416-327-4300
Fax: 416-326-1571
www.gov.on.ca/health

June 10, 2003

The Honourable Mr. Justice Archie G. Campbell
130 Queen Street West
Toronto, ON M5H 2N5

Dear Mr. Justice Campbell:

This letter will confirm your appointment as an independent Investigator, pursuant to section 78 of the *Health Protection and Promotion Act*, to investigate the recent introduction and spread of Severe Acute Respiratory Syndrome (SARS). I would like to express my thanks for your valuable input into the development of the Terms of Reference for this inquiry, a copy of which is appended hereto.

As you are aware, persons who disclose information to you in the course of your investigation will be protected from any adverse employment action, pursuant to Section 9.1(1) of the *Public Inquiries Act*.

As indicated in the Terms of Reference, you will deliver your reports to me and I will release them to the public. You will receive resources and support staff through the Ministry of the Attorney General, pursuant to paragraph 7 of the Terms of Reference.

In accordance with the attached Order in Council, all Government ministries, agencies, boards and commissions and their employees have been directed to co-operate with your investigation and to respect its independence.

On behalf of the Government and the people of Ontario, I thank you for agreeing to accept this most important mandate.

Yours very truly,

Tony Clement
Minister

Appendix E: Order in Council

Ontario
Executive Council
Conseil exécutif

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit:

WHEREAS the Minister of Health and Long-Term Care has appointed the Honourable Mr. Justice Archie G. Campbell to investigate the recent introduction and spread of Severe Acute Respiratory Syndrome ("SARS") pursuant to section 78 of the *Health Protection and Promotion Act*;

WHEREAS the Minister of Health and Long-Term Care has provided Mr. Justice Campbell terms of reference for the investigation in a letter dated June 10, 2003;

WHEREAS persons who disclose information to Justice Campbell in the course of his investigation will be protected from any adverse employment action;

AND WHEREAS it is desirable to support Mr. Justice Campbell's investigation and to mandate full co-operation with him by all Government ministries, boards, agencies and commissions:

ALL Government Ministries, Boards, Agencies and Commissions, and their employees, shall assist Mr. Justice Campbell to the fullest extent in order that he may carry out his investigation;

ALL Government Ministries, Boards, Agencies and Commissions shall respect the independence of the investigation;

THE Attorney General shall furnish Mr. Justice Campbell with the resources and support referred to in paragraph 7 of the terms of reference for the investigation.

Recommended: ____________________
Minister of Health and Long-Term Care

Concurred: ____________________
Chair of Cabinet

Approved and Ordered: June 10, 2003
Date

____
Lieutenant-Governor

O.C./Décret 1230/2003

Appendix F: Terms of Reference

Independent SARS Commission
Terms of Reference

1. The subject matter of the investigation shall be:

    (a) how the SARS virus was introduced here and what measures, if any, could have been taken at points of entry to prevent its introduction;

    (b) how the SARS virus spread;

    (c) the extent to which information related to SARS was communicated among health care workers and institutions involved in dealing with the disease;

    (d) whether health care workers and patients in health care treatment facilities and long-term care facilities were adequately protected from exposure to SARS, having regard for the knowledge and information available at the time;

    (e) the extent of efforts taken to isolate and contain the virus and whether they were satisfactory or whether they could have been improved;

    (f) existing legislative and regulatory provisions related to or that have implications for the isolation and containment of infectious diseases, including the quarantine of suspected carriers;

    (g) any suggested improvements to provincial legislation or regulations, and any submissions that the Province of Ontario should make concerning desirable amendments to federal legislation or regulations; and,

    (h) all other relevant matters that Mr. Justice Campbell considers necessary to ensure that the health of Ontarians is protected and promoted and that the risks posed by SARS and other communicable diseases are effectively managed in the future.

2. The investigation shall be conducted in a manner that does not impede ongoing efforts to isolate and contain SARS.

3. Mr. Justice Campbell may request any person to provide relevant information or records to him where he believes that the person has such information or records in his, hers or its possession or control.

4. Mr. Justice Campbell shall hold such public or private meetings as he deems advisable in the course of his investigation.

5. Mr. Justice Campbell shall conduct the investigation and make his report without expressing any conclusion or recommendation regarding the civil or criminal responsibility of any person or organization, without interfering in any ongoing criminal, civil or other legal proceedings, and without making any findings of fact with respect to civil or criminal responsibility of any person or organization.

6. Mr. Justice Campbell shall produce an interim report at his discretion and deliver it to the Minister of Health and Long-Term Care who shall make the report available to the public. Upon completion of his investigation, Mr. Justice Campbell shall deliver his final report containing his findings, conclusions and recommendations to Minister of Health and Long-Term Care who shall make such report available to the public.

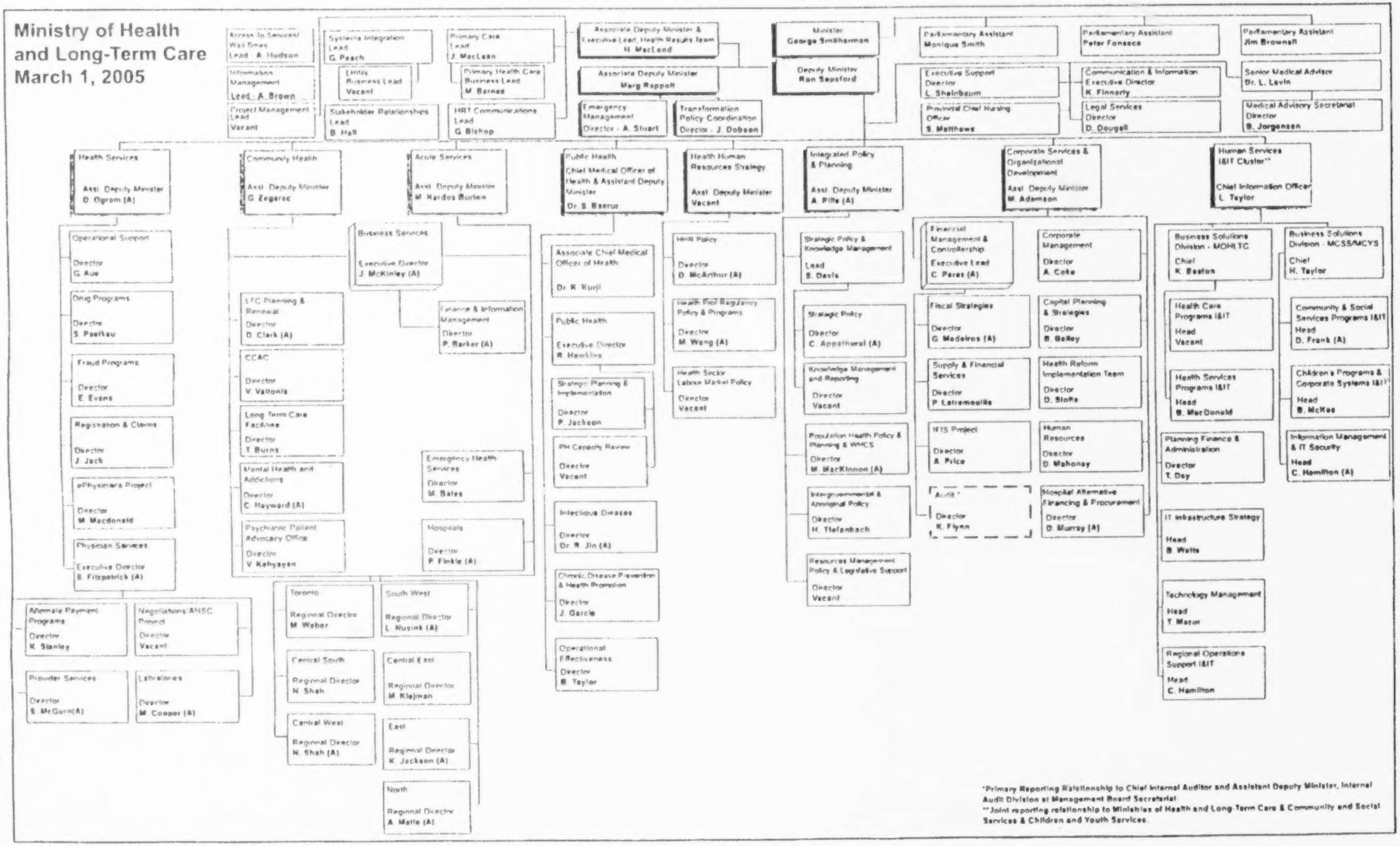
7. To conduct his investigation Mr. Justice Campbell shall be provided with such resources as are required, and be authorized by the Attorney General and shall have the authority to engage lawyers, experts, research and other staff as he deems appropriate, at reasonable remuneration approved by the Ministry of the Attorney General.

8. The reports shall be prepared in a form appropriate for release to the public, pursuant to the *Freedom of Information and Protection of Privacy Act.*

9. These terms of reference shall be interpreted in a manner consistent with the limits of the constitutional jurisdiction of the Province of Ontario.

In the event that Mr. Justice Campbell is unable to carry out any individual term of his mandate, the remainder of these terms of reference shall continue to operate, it being the intention of the Minister of Health and Long-Term Care that the provisions of these terms of reference operate independently.

Appendix G: Organization Chart of the Ministry of Health and Long-Term Care


Ministry of Health and Long-Term Care March 1, 2005
Access to Services/ Wait Times Lead A. Hudson
Information Management Lead A. Brown
Project Management Lead Vacant
Systems Integration Lead G. Peach
LHINs Business Lead Vacant
Stakeholder Relationships Lead B. Hall
Primary Care Lead J. MacLean
Primary Health Care Business Lead M. Barnes
HRT Communications Lead G. Bishop
Associate Deputy Minister & Executive Lead, Health Results Team H. MacLeod
Associate Deputy Minister Marg Rappolt
Emergency Management Director - A. Stuart
Transformation Policy Coordination Director - J. Dobson
Minister George Smitherman
Deputy Minister Ron Sapsford
Parliamentary Assistant Monique Smith
Parliamentary Assistant Peter Fonseca
Parliamentary Assistant Jim Brownell
Executive Support Director L. Sheinbaum
Provincial Chief Nursing Officer S. Matthews
Communication & Information Executive Director K. Flinnerty
Legal Services Director D. Dougall
Senior Medical Advisor Dr. L. Levin
Medical Advisory Secretariat Director B. Jorgensen
Health Services Asst. Deputy Minister D. Ogrom (A)
Operational Support Director G. Aue
Drug Programs Director S. Peelhau
Fraud Programs Director E. Evans
Registration & Claims Director J. Jack
ePhysicians Project Director M. Macdonald
Physician Services Executive Director B. Fitzpatrick (A)
Alternate Payment Programs Director K. Stanley
Negotiations/AHSC Project Director Vacant
Provider Services Director S. McGurn(A)
Laboratories Director M. Cooper (A)
Community Health Asst. Deputy Minister G. Zegarac
LTC Planning & Renewal Director D. Clark (A)
CCAC Director V. Valtonis
Long Term Care Facilities Director T. Burns
Mental Health and Addictions Director C. Hayward (A)
Psychiatric Patient Advocacy Office Director V. Kehyayan
Acute Services Asst. Deputy Minister M. Kardos Burton
Business Services Executive Director J. McKinley (A)
Finance & Information Management Director P. Barker (A)
Emergency Health Services Director M. Bates
Hospitals Director P. Finkle (A)
Toronto Regional Director M. Weber
South West Regional Director L. Nusink (A)
Central South Regional Director N. Shah
Central East Regional Director M. Klejman
Central West Regional Director N. Shah (A)
East Regional Director K. Jackson (A)
North Regional Director A. Matte (A)
Public Health Chief Medical Officer of Health & Assistant Deputy Minister Dr. S. Basrur
Associate Chief Medical Officer of Health Dr. K. Kurji
Public Health Executive Director R. Hawkins
Strategic Planning & Implementation Director P. Jackson
PH Capacity Review Director Vacant
Infectious Diseases Director Dr. R. Jin (A)
Chronic Disease Prevention & Health Promotion Director J. Garcia
Operational Effectiveness Director B. Taylor
Health Human Resources Strategy Asst. Deputy Minister Vacant
HHR Policy Director D. McArthur (A)
Health Prof Regulatory Policy & Programs Director M. Wong (A)
Health Sector Labour Market Policy Director Vacant
Integrated Policy & Planning Asst. Deputy Minister A. Piffe (A)
Strategic Policy & Knowledge Management Lead S. Davis
Strategic Policy Director C. Appathurai (A)
Knowledge Management and Reporting Director Vacant
Population Health Policy & Planning & WHCS Director M. MacKinnon (A)
Intergovernmental & Aboriginal Policy Director H. Tiefenbach
Resources Management Policy & Legislative Support Director Vacant
Corporate Services & Organizational Development Asst. Deputy Minister M. Adamson
Financial Management & Controllership Executive Lead C. Perez (A)
Fiscal Strategies Director G. Medeiros (A)
Supply & Financial Services Director P. Latremouille
IFIS Project Director A. Price
Audit* Director K. Flynn
Corporate Management Director A. Cole
Capital Planning & Strategies Director B. Bailey
Health Reform Implementation Team Director D. Stolte
Human Resources Director D. Mahoney
Hospital Alternative Financing & Procurement Director D. Murray (A)
Human Services I&IT Cluster** Chief Information Officer L. Taylor
Business Solutions Division - MOHLTC Chief K. Beaton
Health Care Programs I&IT Head Vacant
Health Services Programs I&IT Head B. MacDonald
Planning Finance & Administration Director T. Day
IT Infrastructure Strategy Head B. Watts
Technology Management Head T. Mazur
Regional Operations Support I&IT Head C. Hamilton
Business Solutions Division - MCSS/MCYS Chief H. Taylor
Community & Social Services Programs I&IT Head D. Frank (A)
Children's Programs & Corporate Systems I&IT Head B. McKee
Information Management & IT Security Head C. Hamilton (A)

*Primary Reporting Relationship to Chief Internal Auditor and Assistant Deputy Minister, Internal Audit Division at Management Board Secretariat

**Joint reporting relationship to Ministries of Health and Long-Term Care & Community and Social Services & Children and Youth Services

Appendix H: Correspondence

- Letter to The Honourable Dalton McGuinty, Premier, from Dr. James Young, Commissioner of Emergency Management, dated June 21, 2004
- Letter to Mr. Phil Hassen, Deputy Minister, Ministry of Health and Long-Term Care, from Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, dated June 30, 2004
- Letter to Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, from Mr. Phil Hassen, Deputy Minister, Ministry of Health and Long-Term Care, dated August 4, 2004
- Letter to The Honourable Mr. George Smitherman, Minister of Health and Long-Term Care, from The Honourable Mr. Justice Archie Campbell, Commissioner, SARS Commission, dated January 17, 2005
- Letter to The Honourable Mr. Justice Archie Campbell, Commissioner, SARS Commission, from The Honourable Mr. George Smitherman, Minister of Health and Long-Term Care, and Mr. Monte Kwinter, Minister of Community Safety and Correctional Services, dated March 14, 2005
- Letter to Ms. Pat Vanini, Executive Director, Association of Municipalities of Ontario, from Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, dated June 30, 2004
- Letter to Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, from Ms. Ann Mulvale, President, Association of Municipalities of Ontario, dated July 19, 2004
- Letter to Ms. Petra Wolfbeiss, Association of Municipalities of Ontario, from Ms. Jennifer Crawford, Assistant Commission Counsel, SARS Commission, dated January 12, 2005

Ministry of Community Safety and Correctional Services

Ministère de la Sécurité communautaire et des Services correctionnels

Ontario

Commissioner of
Emergency Management

Commissaire à la
Gestion des situations d'urgence

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Téléc. : 416-314-3388

PS04-00156

June 21, 2004

The Honourable Dalton McGuinty
Premier
Legislative Building, Room 281
Queen's Park
Toronto ON M7A 1A1

Dear Premier McGuinty,

I appreciated the recent opportunity to discuss emergency management with you and would like to provide some of my thoughts in writing.

First let me state that, in my opinion, the Province is better prepared than ever, in terms of emergency preparedness and response capability. Since September 11, 2001, the Ministry of Community Safety and Correctional Services (formerly Public Safety and Security) has implemented a number of emergency management and counter-terrorism initiatives, including generic and specialized training for emergency first responders, an expansion of the OPP Hate Crime Extremists Unit, and enhancements to Emergency Management Ontario (EMO).

On December 1, 2003, former Federal Solicitor General Wayne Easter and Ontario Minister of Community Safety and Correctional Services Monte Kwinter signed a memorandum of understanding (MOU) authorizing the development of protocols for police services in response to threats to the security of Canada and to Internationally Protected Persons (IPPs). This new arrangement is an important part of Ontario's counter-terrorism plan because it will help ensure that the RCMP and their provincial and municipal partners continue to collaborate effectively on national security issues.

Although we have made significant advancements in the Province's state of emergency preparedness, the risk situation from a number of factors including terrorism, global warming, interconnected and aging infrastructure, and pandemics is greater today than at any point in the province's history. We continue to address these issues at all levels of government and are making steady progress in our ability to respond.

.../2

Clearly, one of the best ways to guide our preparation is to learn from our past experiences. With this goal in mind, I would like to specifically comment on some deficiencies in our emergency legislation. The 1998 ice storm and particularly the 2003 SARS and power blackout emergencies, have demonstrated limits in our current legislation.

In the event of a declared provincial emergency, the *Emergency Management Act* concentrates existing legislative power in your hands, but does not add any additional powers to manage the unique issues that arise during an emergency. For example, it is not clear if you could force an evacuation or control the distribution or price of vital supplies such as gas, electricity or medical protective equipment. In concert with other ministries, we have been looking at a range of potential powers and comparing our proposed approach with existing legislation in other provinces. Currently, Ontario has the weakest legislation in the country. The additional powers we have considered appear in other provincial or federal legislation and most of the legislation describes these powers in similar ways. Any additional powers, of course, must be used carefully in an emergency and an accountability mechanism should be built into their use. The overriding principle, however, is that these powers are necessary to protect public safety in an emergency situation.

I believe that our research and analysis has evolved to a point where we can offer constructive and comprehensive advice to you concerning necessary legislative amendments to the *Emergency Management Act*.

For your information, I am attaching to this letter a jurisdictional analysis of emergency powers legislation in other provinces.

I look forward to working together to address the challenges that face the Province with respect to these issues.

Sincerely,

James Young MD

James G. Young, M.D.
Commissioner of Emergency Management

Enclosure

c: The Honourable Monte Kwinter
Minister of Community Safety and Correctional Services

bc: Mr. W. Michael Fenn
Deputy Minister, Community Safety

APPENDIX A

Enumerated Emergency Powers Across Canada

Power	Canada	BC	AB	SK	MB	ON	QC	NB	PEI	NS	NF
Implement Emergency Plans		X	X	X	X	X	X	X	X	X	X
Regulate or Prohibit Travel	X	X	X	X	X		X	X	X	X	X
Evacuate	X	X	X	X	X		X	X	X	X	X
Requisition, Use or Destroy Property	X	X	X	X	X		X	X	X		X
Mandatory Recruitment	X	X	X	X	X		X	X	X	X	X
Establish Emergency Facilities	X			X							X
Procure & Distribute Necessary Goods and Services	X	X	X	X	X		X	X	X	X	X
Construct Works		X					X				
Close public and private establishments	X						X		X		X
Fix prices		X	X	X				X			X
Restore Necessary Facilities		X	X	X	X			X	X	X	X
Authorize paid leaves of absence (job protection)											
Require disclosure of information							X				
Entry without warrant		X	X	X	X		X	X	X	X	X
Other matters considered necessary (general emergency power)	X	X	X	X	X		X	X	X	X	X
Curfews	*Can be imposed pursuant to general emergency power (ex. Curfew imposed in Halifax during the 2004 blizzard)										

**COMMISSION TO INVESTIGATE
THE INTRODUCTION AND SPREAD
OF SARS IN ONTARIO**

Ontario

The Honourable Archie Campbell, Commissioner

180 Dundas Street West, 22nd Floor
Toronto, ON M5G 1Z8

Tel: (416) 212-6878

Fax: (416) 212-6879

Douglas C. Hunt, Q.C.
Commission Counsel

Direct: (416) 212-6868
Email:
douglas.hunt@jus.gov.on.ca

June 30, 2004

Mr. Phil Hassen
Deputy Minister
Ministry of Health and Long-Term Care
Hepburn Block
80 Grosvenor St., 10th Floor
Toronto, ON M7A 1R3

Dear Mr. Hassen:

Re: SARS Commission

The Commission's terms of reference require it to investigate and report on any suggested improvements to provincial legislation or regulations, and any submissions that the Province of Ontario should make concerning desirable amendments to federal legislation or regulations.

The Commission intends to make recommendations on legal lessons learned from SARS including recommendations in respect of the *Emergency Management Act*, the *Health Protection and Promotion Act*, specific health emergency legislation and the emergency use of confidential health records.

Occupational Health and Safety Legislation will be addressed separately and we will be in touch with you in late summer or early fall in that regard.

Without detracting from the generality of the four issues set out above, the attached list contains a few specific examples to illustrate the range of issues potentially involved.

It would be helpful to have the views and recommendations of you and your Ministry in respect of these issues, in writing by the end of July, and any suggestions you might have as to matters that the Commission should consider in approaching these issues and people in your ministry whom we should consult.

We are grateful for the assistance you and your Ministry has given the Commission and look forward to your further help.

Yours truly,

D Hunt

Douglas C. Hunt, Q.C.
Commission Counsel

cc. Justice Archie Campbell

POSSIBLE ISSUES RE LEGISLATION

Emergency Management Act

- Recommendations for powers;
- Recommendations for accountability measures and safeguards;
- Any lack of clarity around legislation and the legal duties and obligations of hospitals, the Chief Medical Officer of Health, local Medical Officers of Health and other public health authorities, physicians and other health care workers that required them to seek legal advice and direction instead of acting immediately.

Special Health Emergency Legislation

- To complement general powers in the *Emergency Management Act*;
- Specifically focused on health emergencies;
- Permitting a staged response short of a general provincial emergency;
- Detailed codification of specific powers & safeguards for health emergencies;
- Generally, health emergency legislation including quarantine and other extraordinary powers and the authority of the government to issue emergency directives to hospitals around issues such as patient transfers, protective equipment for workers, infection control procedures, and the whole range of issues covered by the directives issued by the Provincial Operations Centre during SARS;
- Any lack of clarity around legislation and the legal duties and obligations of hospitals, the Chief Medical Officer of Health, local Medical Officers of Health and other public health authorities, physicians and other health care workers that required them to seek legal advice and direction instead of acting immediately.

Emergency Use of Confidential Health Information

- Any legal obstacles to the ability of those managing the outbreak, including public health officials and the Ministry of Health, to access, share and use confidential personal health information about cases (suspect, probable and those under investigation) and their contacts and recommendations for how to resolve those legal obstacles;
- Any issues that arose from the perspective of patients, health care workers, and custodians of health records, about the acquisition, release and use of confidential health information and recommendations to address these issues;
- Any lack of clarity around legislation and the legal duties and obligations of hospitals, the Chief Medical Officer of Health, medical officers of health and other public health authorities, physicians and other health care

workers that required them to seek legal advice and direction instead of acting immediately.

Health Protection and Promotion Act

- The role of the Minister of Health, the new role and independence of the Chief Medical Officer of Health and the local Medical Officers of Health, the structure and authority of local health units and the new proposed agency, and any suggestions for a general overhaul, streamlining, and modernization of the *Health Protection and Promotion Act*;
- The powers of the Chief Medical Officer of Health and local Medical Officers of Health in respect of infectious outbreaks including quarantine powers and other orders;
- The legal form and content of the Mandatory Health Guidelines or any machinery that replaces them:
    - legal authority for them;
    - legal enforceability mechanisms;
    - should they be in form of regulation or statutory instrument?
    - how to deal with noncompliance.
- Accountability and authority to designate a case as SARS or any other infectious disease: respective roles of public health units, hospitals, doctors, the public health branch, and the "adjudication" process used during SARS;
- Accountability and authority of public health units, the public health branch, and hospitals around infection control generally and the investigation of possible or suspected hospital outbreaks;
- Any lack of clarity around legislation and the legal duties and obligations of hospitals, the Chief Medical Officer of Health, local Medical Officers of Health and other public health authorities, physicians and other health care workers that required them to seek legal advice and direction instead of acting immediately.

Ministry of Health
and Long-Term Care

Office of the Deputy Minister

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Ministère de la Santé
et des Soins de longue durée

Bureau du Sous-Ministre

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80 rue Grosvenor
Toronto ON M7A 1R3
Tél (416) 327-4296
Téléc (416) 326-1570

Ontario

AUG - 4 2004

Mr. Douglas C. Hunt, Q.C.
Commission Counsel
Commission to Investigate
The Introduction and Spread of SARS in Ontario
180 Dundas Street West, 22nd Floor
Toronto, ON M5G 1Z8

Dear Mr. Hunt:

I am responding to your letter dated June 30, 2004. Thank you for providing the Ministry of Health and Long-Term Care with the opportunity to submit our views on these important issues.

The comments outlined below are in addition to information already provided to you by Ministry staff in recent interviews. I would also note that the recommendations set out in this letter are based on research and work that has been undertaken within the Ministry of Health and Long term Care at the staff level, and do not represent formal government policy as approved by Cabinet.

Emergency Management Act

Consistent with the recommendations in your report, the government is currently reviewing the *Emergency Management Act* ("EMA"). In addition, as you know, the Standing Committee on Justice Policy is currently in the process of reviewing the adequacy of Ontario's emergency management statutes and is expected to file its report in the next few months.

During SARS, we recognized that the powers under that Act are not as extensive as may be required in certain emergencies, particularly when compared to the powers found in other jurisdictions. It is our view that the lack of those powers did not hinder the ability to respond during the SARS emergency given the goodwill and co-operation of all involved. However, we do think it may put the government and public at some risk to count on goodwill and co-operation in future, particularly as the range and seriousness of potential emergencies increases. As a result, Ministry staff are of the view that Ontario's EMA should be revised to ensure that a broad and flexible range of emergency powers are available to government during an emergency.

I understand that Dr. James Young, the Commissioner of Emergency Management, and representatives from the Ministry of the Attorney General have spoken to you or are scheduled to speak to you about the range of powers that should be available to the province and the necessary constitutional safeguards that should be placed on the exercise of those powers. While I defer to those individuals on these issues, I would observe the necessity of ensuring that quick and appropriate action can be taken at a level that is operationally feasible and efficient when facing an emergency.

Health Specific Legislation

Although your letter and attachment refer to separate health emergency legislation, we do not believe at this point that separate health emergency legislation is necessary in light of the current direction to create broad emergency response powers. Our main concern would be the duplication, confusion and legal challenges that could result from the existence of both broad emergency response and health specific legislation.

However, within the framework of broader emergency response powers, we have been considering enhancements that may be required in our legislation to address specific program issues as they arise in (or prior to or after) any emergency. For example, we will be considering various ways of clarifying the authority to issue directives prior to, during, or after an emergency. This could be achieved by including a general provision in the *Ministry of Health and Long-Term Act*, or provisions in program specific legislation (i.e., legislation governing public hospitals, laboratories, long-term care facilities, etc.).

There is also the possibility of enhancing the ability of the Chief Medical Officer of Health to take action or provide directions as required in any circumstance relating to a public health emergency. A further complementary amendment is to provide a mechanism to expedite the registration of health care professionals in an emergency, and possibly before or after an emergency, to ensure that professionals registered in other jurisdictions could come to Ontario and practice on short notice. This would require amendments under the *Regulated Health Professions Act* and related legislation.

In addition to these potential changes, specific amendments to the *Health Protection and Promotion Act* are discussed in more detail below.

Health Protection and Promotion Act

The current *Health Protection and Promotion Act* ("HPPA") provides extensive powers to address public health issues throughout Ontario. As you know, over the coming year we would initiate changes that will enhance the role of the Chief Medical Office of Health ("CMOH"), increasing the independence of that office through mandatory reports to the public and increasing the transparency of the appointment process. We hope to proceed with those amendments this fall.

In addition to those changes, we have identified a range of amendments that would work within the framework of broad emergency powers under the EMA. The key to the exercise of these powers would be the necessity of a declaration of an emergency under the EMA and any exercise of the powers would be subject to the constitutional safeguards under the EMA. The main goal of these amendments is to ensure that public health officials have the necessary, extraordinary powers under the HPPA to address a public health emergency if and when one is declared under the EMA. With those parameters in mind, we believe that the following amendments should be considered:

- Authorizing the CMOH to take such action as he or she considers appropriate to decrease the risk presented by the public health emergency.
- Adding new Order provisions to provide for:
  - Mass immunization of individuals or populations, or requiring the isolation of persons where medical contraindications warrant exception from the required immunization;
  - Decontamination in emergency situations, where such action is considered appropriate (decontamination orders are not currently found under the Act, but such procedures may be required for individuals or large groups in the event of a nuclear disaster); and
  - Such other orders as may be necessary in an emergency.
- Authorizing medical officers of health to enter any premises, including a private residence, without a warrant, where the medical officer has reasonable and probable grounds to believe there is a risk to health due to a health hazard or a infectious disease.
- Authorizing the CMOH to order collection, analysis, and retention of any laboratory specimen from any person, animal, plant, or anything the CMOH specifies, and to acquire previously collected specimens and test analyses from any one, and to disclose the results of test analyses as the CMOH considers appropriate.
- Authorizing the CMOH to require any person, organization, government agency or other entity to report information to the CMOH as she or he considers necessary, to reduce prevent or eliminate the risk of the emergency.
- Requiring physicians and other regulated health professionals, hospital administrators and operators of other health care institutions to report such information as the medical officer of health considers necessary in the circumstances (at present, physicians and other regulated health professionals are required to report "such additional information" about a reportable or communicable disease case as the medical officer of health considers necessary, under section 1(2) of Regulation 569 – Reports).
- Adding the CMOH to those currently protected from exposure to liability under the Act, such as medical officers of health and members of boards of health. (But note that this proposal would not be restricted to emergency situations.)

Privacy issues

It is our view that the new *Personal Health Information Protection Act, 2004* (PHIPA) resolves any concerns relating to "legal obstacles" and "lack of clarity" as outlined in your attachment entitled "Possible Issues Re Legislation". The passage of PHIPA received unanimous support in the Legislature. During the Committee hearings on the bill, there was no criticism that the proposed Act failed to address the concerns raised during the SARS outbreak.

The *Personal Health Information Protection Act, 2004*, which comes into force on November 1, 2004, allows "health information custodians" (broadly defined to include the Ministry of Health and Long-Term Care, hospitals, labs, health care practitioners, medical officers of health, boards of health etc.) to disclose "personal health information" (also broadly defined) in a number of circumstances, without patient/client consent.

(1) to a prescribed person who compiles or maintains a registry of personal health information for purposes of facilitating or improving the provision of health care or that relates to the storage or donation of body parts or bodily substances [s.39(1)(c)] (regulations need to be developed now itemizing the registries)
(2) to the Chief Medical Officer of Health or a medical officer of health within the meaning of the Health Protection and Promotion Act if the disclosure is made for a purpose of that Act [s.39(2)(a)]. This permission is broader than the duty to report under the HPPA. The purpose of the HPPA, as set out in s.2 is : "to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario."

(3) to a public health authority that is similar to the persons described in clause 39(2)(a) and that is established under the laws of Canada, another province or a territory of Canada or other jurisdiction, if the disclosure is made for a purpose that is substantially similar to a purpose of the HPPA [s.39(2)(b)]

(4) if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons

(5) subject to the requirements and restrictions, if any that are prescribed, if permitted or required by law or a treaty, agreement or arrangement made under an Act or an Act of Canada [s.43(1)(h), s.43(2)] For example, the disclosure can occur to Statistics Canada or Health Canada if permitted under relevant Acts. Critically, any disclosures permitted or required under HPPA are preserved.

(6) for research purposes as set out in s.44

(7) to a prescribed entity (such as CIHI or ICES - regulations need to be finalized here) for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part of the health system, including the delivery of services, if the entity meets the requirements as set out in the legislation [s.45].

In addition to specific provisions addressing disclosures without consent, the health information custodians can rely on an implied patient/client consent for the disclosure of personal health information to other health information custodians where the disclosure is for the purposes of providing health care or assisting in the providing health care to the patient, unless the patient expressly withholds or withdraws consent [20(2)]. Where consent has been withheld or withdrawn for purposes of health care, this would not preclude the health information custodian from disclosing personal health information without consent as otherwise authorized by PHIPA (as set out above, items 1-7).

Within the health information custodian, such as a hospital, there is also a provision that enables the custodian to use the personal health information without consent in a number of specified circumstances, such as "for the purpose of risk management, error management or for the purpose of activities to improve or maintain the quality of any related programs or services of the custodian" [s.37(1)(d)]. This would include the use of personal health information to comply with a public health surveillance program or a communicable disease surveillance program.

As a general proposition, the health information custodian may collect, use and disclose personal health information as permitted by PHIPA. This means that where the custodian may do so, the custodian may exercise his or her or its discretion to do so or not do so. If the discretion is exercised reasonably and in good faith, the custodian is protected from liability [s.71(1)]. Where another Act requires disclosure, a custodian must not exercise discretion in such a situation and this is specifically addressed in s.6(3)(b).

If Ontario had had a PHIPA in place during the SARS outbreak, all of these provisions that have been highlighted would have provided greater clarity around information sharing. PHIPA, therefore, addresses the perceived "lack of clarity" or "legal obstacles" facing various health information custodians during the SARS outbreak. The legislation, however, is complex as the rules cover a broad range of custodians and recipients. We cannot say, therefore, that this new Act is so clear that it would preclude health care providers from "seeking legal advice and direction instead of acting immediately". Even if legislation were to be written in mandatory language, this may not alleviate concerns of those who need to rely on it for authority to do something or refrain from doing something. PHIPA does clearly set out that custodians, such as hospitals, nursing homes, nurses and doctors, can disclose personal health information to the Chief Medical Officer of Health or a medical officer of health or a person with similar authority in another province and ultimately does provide protection from liability to those providers who exercise their discretion reasonably in the circumstances.

Educational materials being produced by the ministry around PHIPA will include information for all health information custodians about these key provisions pertaining to public health.

Thank you again for the opportunity to provide our views on these issues.

Yours truly,

Phil Hassen
Deputy Minister

c. Dr. Sheela Basrur
Allison Stuart

THE SARS COMMISSION

The Honourable Archie Campbell
Commissioner

Ontario

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January 17, 2005

The Honourable Mr. George Smitherman
Minister of Health and Long-Term Care
80 Grosvenor Street
10th Floor
Toronto, Ontario

Dear Mr. Smitherman:

Progress Report

Further to the Commission's first interim report in April of 2004, this letter reports our work now in progress.

Need For Second Interim Report

The government has stated its intention to proceed with the reform of the *Health Protection and Promotion Act* and the development of emergency legislation. In order that the Commission's work on these issues be presented in a timely fashion, a further interim report is therefore required.

The second interim report is expected next month and will deal with many aspects of these issues including:

- further measures to strengthen the office of the Chief Medical Officer of Health and the Medical Officers of Health throughout the province;
- further measures to strengthen the *Health Protection and Promotion Act;*
- the need for enhanced public health resources to honour the government's commitment to move forward with the recommendations of the Naylor Report, the Walker Report, the Commission's first interim report, and the commitments in Operation Health Protection; and
- the independent role of the Chief Medical Officer of Health in respect of medical decisions and precautions in a public health emergency, and the powers required to respond to a public health emergency.

Emergency Powers and Bill 138

In respect of Bill 138, the emergencies bill now before the Legislative Assembly, the Commission has no specific mandate. The bill does, however, affect public health emergencies, an issue at the heart of the Commission's work and terms of reference. It is impossible to deal with public health emergencies outside the context of Bill 138 and it is therefore necessary to make some observations on this proposed legislation. The Commission's limitation is that I do not as a judge want to be perceived as entering the political arena in respect of a bill that stands to be debated in the Legislative Assembly.

Within those limitations, something must be said in the Commission's interim report about Bill 138, which reflects the dedicated work of the Standing Committee on Justice policy, its public hearings last summer, its report, and its important bill.

Bill 138: Unprecedented Powers

The proposed powers are remarkable. Bill 138 would give government officials enormous emergency powers to make any order they consider necessary and the power to disobey virtually every law now in force in Ontario. Even with the safeguards proposed by the Committee, no one in Ontario's history has ever sought to delegate so much power to government officials.

Proposed powers of this nature, before they are adopted by any government, require the most searching legal and constitutional scrutiny.

Judges have often warned about the inherent danger that every emergency power, once conferred,

> …lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need[1].

While the Committee proposed a number of safeguards to address these concerns, Bill 138 continues to present questions of legal and constitutional policy at the heart of our system of government in Ontario. These issues include the question whether inherent powers of the kind used in the 1979 Mississauga derailment and referred to in the 1981 Solicitor General's discussion of emergency measures are still adequate and the further question of the degree to which it is constitutionally and legally appropriate to give government officials virtually unfettered power to set aside the ordinary laws of the province and to do whatever they consider necessary in unspecified circumstances. The issues include the question whether the proposed powers are adequate to do the job and the selection of the best legal machinery to achieve the right balance between effective, flexible emergency action and the safeguards required to protect fundamental rights and freedoms.

Bill 138: Process to Date

In the ordinary course, any statute touching on such fundamental legal issues would originate as a government bill with a number of benefits not available in the process that produced Bill 138. These advantages include the internal governmental policy development process that ensures that every bill reflects an analysis of the practical workability of the bill from the point of view of the government departments that have to make the bill work once it is passed. More fundamentally these advantages include a searching review by Crown law officers in the Attorney General's Department of the structure, constitutionality, legal policy, and drafting of the bill.

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[1] Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the arbitrary race-based internment of Japanese Americans during WW II.

As noted during the proceedings of the Justice Committee, Bill 138 as a private member's bill was not supported by the resources associated with a government bill in terms of research, policy development, legal expertise and constitutional analysis, and consistency with the basic legal policies underlying all Ontario laws. It would be unique for a private member's bill, unsupported by such resources, to deal in any final manner with the fundamental legal issues associated with general emergency legislation that goes to the heart of Ontario's legal system.

Bill 138, although it reflects in part the very preliminary discussion draft produced by staff at the Attorney General's Department and reflects also the important work of the Justice Committee, lacks the advantages associated with the ordinary legislative process described above. It is clear from the Committee's proceedings that the draft bill prepared by Ministry staff was originally prepared as a temporary stop-gap measure in the contingency that an emergency might strike before there was time for the preparation of a government bill, that it was never intended as a long-term answer to the problems of emergency legislation, and that it never received formal consideration by the Attorney General or the government. It does not appear that the government as a whole, or the Attorney General's department in particular, was involved in any comprehensive policy and operational review of Bill 138 and its underlying issues.

Bill 138 and the Commission's Interim Report

Because Bill 138 reflects so much dedicated work in respect of all emergencies, including public health emergencies, it would be inappropriate for the Commission to duplicate the work of the Committee.

It is necessary, however, for the Commission in its forthcoming interim report to make specific recommendations in respect of public health emergency issues that are not addressed in Bill 138, such as the role of the Chief Medical Officer of Health, in light of the lessons learned from SARS, in a public health emergency.

It is also necessary for the Commission to note some of the underlying constitutional and legal policy issues in Bill 138 that require thorough and expert legal consideration.

Bill 138: Choices

It is entirely a matter for the government and the Legislative Assembly to decide how they wish to proceed with Bill 138 and it would be presumptuous for the Commission to offer any advice on what is essentially a political matter.

It is however appropriate to point out some of the choices in relation to Bill 138 and the consequences of those choices.

If Bill 138 proceeds through second reading and committee, there will be no opportunity for the government as a whole and the Attorney General's Department in particular to perform the comprehensive review and analysis of options that ordinarily accompanies any legislation of such great public importance before it is submitted to the Legislative Assembly for final debate, amendment, and passage.

If the government takes Bill 138 as a helpful starting point and produces a government bill, building on the excellent work of the Committee, it would enable the kind of internal process one associates with legislation of such far-reaching legal consequences. The Legislative Assembly and the public would then have the double advantage of the work of the Justice Committee and the internal governmental processes that have been bypassed so far.

The Attorney General's Role

One consequence of Bill 138 process is that the Attorney General has not been publicly involved, except to the extent that staff in his Ministry assisted the Committee with a very preliminary discussion draft.

The Attorney General has a central role in the assessment of any legal measure adopted by the government. This role is crucially important with a fundamental and far reaching measure like Bill 138. The government, the Legislative Assembly, and the public require the advice and assistance of the Attorney General in respect of this extraordinary legislation that engages the most fundamental values in our legal system.

It is rare for the Attorney General to release publicly the advice and opinions of his Crown law officers. It is not so unusual for the Attorney General to provide the public and the Legislative Assembly, in the form of a white paper or a green paper or a discussion paper, some analysis of the legal and constitutional issues and choices presented by a subject like emergency legal powers.

It is my respectful submission that the public interest in the legal and constitutional integrity of any proposed emergency powers legislation requires the public involvement of the Attorney General in whatever way he considers most appropriate.

Because of the references to his role and office, I take the liberty of sending to the Attorney General a copy of this letter, which will form an appendix to the Commission's forthcoming interim report.

Yours truly,

Archie Campbell

cc. The Honourable Michael J. Bryant, Attorney General for Ontario

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Ontario

MAR 14 2005

The Honourable Archie Campbell
Commissioner
The SARS Commission
180 Dundas Street West, 22nd Floor
Toronto, Ontario M5G 1Z8

Dear Justice Campbell:

Thank you for your letter dated January 17th, 2005 in which you provide an update and anticipated timing for the release of your second interim report.

We understand that the upcoming report will focus mainly on public health and proposed amendments to the *Health Protection and Promotion Act* (HPPA). In addition to amendments to the HPPA, you have referred to powers of the Chief Medical Officer of Health in the course of a "public health emergency". While we are committed to ensuring that the Chief Medical Officer of Health has the necessary powers under HPPA to address issues as they arise under that legislation, including powers available in any emergency, and we will continue to look at how best this can be achieved, we do not feel that a separate definition of "public health emergency" per se achieves this goal in a clear manner.

I, the Minister of Health and Long-Term Care, have sought the advice of the Chief Medical Officer of Health and she has expressed to me her reservations on this point, including the risk of potential confusion that could arise with dual definitions of emergency. In our view, it would be difficult to imagine an emergency that does not have some public health component or risk. Therefore, while the concept of clear roles for a CMOH in an emergency is clearly one we agree with, the manner in which this is achieved requires careful examination. We therefore look forward to reviewing your report in full and particularly your detailed comments on this matter.

With respect to your comments on Bill 138, and as you are aware, the Standing Committee on Justice Policy developed Bill 138. The Committee's mandate was to review and report on the adequacy of Ontario's emergency management statutes and to authorize the text of a draft bill. In addition to the draft bill, the Standing Committee produced a report setting out 22 recommendations regarding emergency management and response in Ontario.

The Committee held extensive public hearings and heard from 92 individuals, representing more than 50 different organizations. The Committee also received written materials from additional organizations and individuals who did not appear in person.

Ministries of the government of Ontario with significant emergency management responsibilities made presentations to the Committee including the Ministries of Community Safety and Correctional Services, Health and Long-Term Care, Attorney General, Agriculture and Food, Municipal Affairs and Housing, Environment, Natural Resources, and Labour.

The government is currently undertaking a thorough review of Bill 138. Ministries with emergency management responsibilities are reviewing the Bill to, among other matters, identify potential areas for improvement in the Bill. The Ministries of Health and Long Term Care, Community Safety and Correctional Services and the Attorney General of course have key roles in this process.

I understand that you recently spoke with the Attorney General and he conveyed his appreciation to you for taking the time to write on the subject of Bill 138 and he is certainly very cognizant of your concerns. The Attorney General asked us to reiterate that we are considering the situation very closely, as you are aware from your meeting with counsel from the Ministries of the Attorney General, Community Safety and Correctional Services, and Health and Long-Term Care. As he discussed with you, the Attorney General is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.

We look forward to reviewing your second interim report on these issues.

Yours truly,

George Smitherman
Minister of Health and Long-Term Care

Monte Kwinter
Minister of Community Safety and Correctional Services

c: The Honourable Michael J. Bryant, Attorney General,
Ministry of the Attorney General
Dr. Sheela V. Basrur, Chief Medical Officer of Health and Assistant Deputy Minister,
Ministry of Health and Long-Term Care

**COMMISSION TO INVESTIGATE
THE INTRODUCTION AND SPREAD
OF SARS IN ONTARIO**

Ontario

The Honourable Archie Campbell, Commissioner

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Commission Counsel

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June 30, 2004

Ms. Pat Vanini
Executive Director
Association of Municipalities of Ontario
393 University Av., Suite 1701
Toronto, ON M5G 1E6

Dear Ms. Vanini:

Re: SARS Commission

The Commission's terms of reference require it to investigate and report on any suggested improvements to provincial legislation or regulations, and any submissions that the Province of Ontario should make concerning desirable amendments to federal legislation or regulations.

The Commission intends to make recommendations on legal lessons learned from SARS including recommendations in respect of the *Emergency Management Act*, the *Health Protection and Promotion Act*, specific health emergency legislation and the emergency use of confidential health records.

Occupational Health and Safety Legislation will be addressed separately and we will be in touch with you in late summer or early fall in that regard.

Without detracting from the generality of the four issues set out above, the attached list contains a few specific examples to illustrate the range of issues potentially involved.

It would be helpful to have your views and recommendations in respect of these issues, in writing by the end of July, and any suggestions you might have as to matters that the Commission should consider in approaching these issues.

We are grateful for the assistance you have given the Commission and look forward to your further help.

Yours truly,

DHunt
Douglas C. Hunt, Q.C.
Commission Counsel

cc. Justice Archie Campbell

AMO
Association of Municipalities of Ontario

OFFICE OF THE PRESIDENT

July 19, 2004

Douglas Hunt, Q.C.
Commission Counsel
Commission to Investigate the Introduction and
Spread of SARS in Ontario
180 Dundas Street West
22nd Floor
Toronto, ON M5G 1Z8

Dear Mr. Hunt:

Re: June 30, 2004 letter on SARS Commission

I would like to thank you for requesting AMO's participation in your Commission's review of the *Emergency Management Act*, the *Health Protection and Promotion Act* and other emergency legislation. As you know, our members have a significant responsibility in this regard, as they are responsible for public health and emergency management in their communities.

We are, however, concerned about the tight timeframes and timing of your consultation process. It was not possible to consult with our members, or provide comprehensive recommendations – nor has our Board of Directors had the opportunity to review the following comments given your deadline.

We would hope that once your report is completed, municipalities and stakeholders will be given the opportunity to review the policy recommendations and provide comments before any of them are approved by the government.

We would also recommend that the Commission limit its focus to policy outcomes, and leave the implementation details to the governments responsible for these services. Our experience from the Walkerton Inquiry points to the need for operations to figure out how best to achieve the defined policy outcomes. We are confident that through the Memorandum of Understanding (MOU) between AMO and the provincial government, policy development and implementation matters can be appropriately handled.

Due diligence is also necessary. Policy proposals should fully analyzed in terms of benefits, costs and other impacts, so decision makers and the public can understand their implications. Obviously, municipalities, because of their emergency management and public health role, should participate in this process. The Commission should also be aware that municipalities each have different risks and capacities, and that one-size fits all approaches are usually fraught with significant costs, and often do not achieve the desired outcomes.

We would also note that should there be additional financial implications, how these new costs are funded, needs to be discussed. This is another issue that would be better left to the MOU table.

Once again, thank you for contacting our Association regarding this vital issue. Unfortunately given the timeframes allotted to respond, our response is not as detailed as we would like, but we look forward to reviewing and commenting on your recommendations. We have forwarded you letter to relevant municipal staff associations. We hope that they will also provide comments to your Commission.

Yours very sincerely,

AMulvale

Ann Mulvale
President

c.c. Hon. George Smitherman, Minister of Health and Long-Term Care
Hon. John Gerretsen, Minister of Municipal Affairs and Housing
Hon. Monte Kwinter, Minister of Community Safety and Correctional Services
Association of Local Public Health Agencies (ALPHA)
Rick Armstrong, President, Association of Municipal Emergency Medical Services of Ontario (AMEMSO)
Ontario Association of Fire Chiefs (OAFC)
Ontario Association of Chiefs of Police (OACP)
Ontario Association of Police Services Boards (OAPSB)
Emergency Management Ontario, Ministry of Community Safety and Correctional Services
Allison Stuart, Director, Emergency Management Unit, Ministry of Health and Long-Term Care
Carol Appathurai, Director, Health, Information, Privacy and Sciences Branch, Ministry of Health and Long-Term Care

**COMMISSION TO INVESTIGATE
THE INTRODUCTION AND SPREAD
OF SARS IN ONTARIO**

Ontario

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[January 12, 2005]

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Dear Ms. Petra Wolfbeiss

Further to our conversation of January 7th, 2005, and your voicemail of yesterday let me confirm my advice about the issues in which the Commission would particularly welcome the views of AMO:

- The Commission's observations and recommendations in the first interim report (April 15, 2004) in relation to the role of municipalities in public health (The Public Health Ping-Pong Game; One Local Funding Problem; The Municipalities' Funding Dilemma; One Local Story; Parry Sound; Public Health Restructuring; Greater Priority for Infectious Disease Control; and Central Control Over Health Protection);
- Role and independence of local medical officers of health in a municipal governance structure;
- Composition and qualifications of members of Boards of Health;
- Possible amendments to the *Health Protection and Promotion Act*;
- Municipal emergency response issues

Any assistance you could provide on any of these issues would be helpful to the Commission.

We hope to schedule a date for the meeting as soon as possible.

Yours truly,

Jennifer Crawford
Assistant Commission Counsel
(416-212-6867)